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Employee engagement, learning and development in an NHS organization

a critical study of employee engagement, public management discourses, and the implications for human resource development

Claire M. Valentin

Preface

Declaration

This thesis has been composed by the candidate, and the work is all the candidate's own. The work has not been submitted for any other degree or professional qualification.

Some material from the thesis has been published before the thesis was submitted, with the approval of the supervisor. All the formerly published material that is included in the thesis is the candidate's own work. Publications are as follows:

Lawless, A., Sambrook, S., Garavan, T. and Valentin, C. (2011) A discourse approach to theorising HRD: opening up a discursive space, *Journal of European Industrial Training*, 35 (3) pp. 264-275.

Valentin, C. (2014) Employee Engagement Interventions: HRD, groups, and teams, in C. Valentin and J. Walton (Eds.) *Human Resource Development: Practices and Orthodoxies*, Palgrave Macmillan, pp. 305-237.

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Dedication

To Fred and Nancy, lifelong learners.

Abstract

This NHS based case study examines the meanings, purposes, attitudes and behaviours attached to the concept of employee engagement (EE) in a health service setting where, although there is increasing interest in its measurement and introducing practices to enhance it, there has been limited research. The study also explores the factors which act as driving and restraining forces to its practical realisation including in particular the contribution of learning and development (L&D).

Adopting a broadly social constructionist position the study incorporates critical management and discourse perspectives. Theory building evolved through a process of abductive, inductive and deductive reasoning, cycling between the data and the literature. The review of academic and practitioner literature draws on research into EE, work engagement, motivation, commitment, human resource development, and health service management.

The empirical study explores staff perceptions of EE, in a shared experience of developing insights into multiple experiences of the social world at work. Semi-structured interviews were held with health service learning and development professionals, and 10 focus groups with 52 staff. These were mainly nurses and allied health professionals and some administrative and support staff.

The research contributes a number of insights into the conceptualization of EE, its application within a health service context, and the contribution of L&D. It finds that EE is a contested construct that is subject to multiple meanings and interpretations; but that neither academic nor practitioner literature fully capture the nuances of individual staff experience. These included experiencing feelings of engagement and disengagement at the same time, and being more engaged with day-to-day work and patient care than with the wider organization. Understanding EE from an employee perspective provides insights into the complexity of engagement and the impact of different contexts. For example drivers for and barriers to EE are seen as complex, situational and personal. L&D can be a driver for engagement, and a number of L&D interventions and practices were identified which contribute to EE, and general and specific factors which support and inhibit L&D are revealed. Given that current conceptualisations of EE focus overly on staff engagement with the organization, a framework is presented for understanding the locus of engagement with other foci such as patients and a profession. The team or work group is identified as a particular locus of engagement. The impact of different contexts on individual engagement emerges as a significant factor. The frameworks and findings may be of relevance to health service and other organizational contexts.

Employee engagement, learning and development in an NHS organization - a critical study of employee engagement, public management discourses, and the implications for human resource development.

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List of abbreviations

CAQDAS	computer aided qualitative data analysis
CMS	critical management studies
EE	employee engagement
HRD	human resource development
HRM	human resource management
HR	human resources
HROD	human resource and organization development
IIP	Investors In People
ISO	International Organization for Standardization
KSF	Knowledge and Skills Framework
L&D	learning and development
NHS	National Health Service
NPM	new public management
OCB	organizational citizenship behaviour
PDP	personal development plan
POS	perceived organizational support
PTS	perceived team support
PWC	Pricewaterhouse Coopers
SHRD	strategic human resource development
T&D	training and development
WE	work engagement

Chapter 1: Introduction to the thesis.

Introduction

This study critically explores the theme of employee engagement and learning and development within NHS Lothian, a large health service organization. The focus of the study is to identify the meanings and purposes of the construct of employee engagement in a National Health Service (NHS) organizational context, examine the contribution of learning and development to employee engagement, and establish the main factors which act as drivers for and barriers to employee engagement. The study takes a social constructionist approach to examine how health service clinical and support staff and learning and development professionals perceive employee engagement. Data was gathered by means of focus groups with nurses, allied health professionals, administrative and support staff from NHS Lothian, semi-structured interviews with professionals involved in learning and development (L&D) and human resource development (HRD) in NHS Lothian and other organizations, and examination of archival data.

The research questions that are addressed in this thesis are:

1. What meanings, purposes, attitudes and behaviours are attached to the concept of employee engagement in a given health service setting?
2. What factors act as drivers for and barriers to employee engagement in this setting?
3. What key learning and development themes contribute to employee engagement in this setting?
4. How can we conceptualize employee engagement within a health service context?

This introduction sets the scene for the thesis. It provides the rationale for the study, and sets out the context. It gives a brief synopsis of the conceptual framework, methodology, and the empirical research, and summarises the structure of the thesis.

Employee engagement and learning and development in the health service context.

Recent years have seen a burgeoning interest in the construct of Employee engagement (EE). William Kahn (1990) coined the term ‘employee engagement’, describing the experience of an engaged individual as being ‘psychologically present’ during ‘work role performances’,

and contrasting this with the experience of ‘disengagement’ (Kahn, 1990: 694). EE has since been described as a combination of commitment to the organization and its values, motivation, job satisfaction, discretionary effort by employees, and a willingness to help out colleagues (CIPD 2008). It is argued that to compete effectively, companies must enable employees to apply their full capabilities to their work. Engagement is said to include a willingness to ‘go the extra mile’ for the employer, and result in improved individual and subsequently organizational performance (CIPD, 2008; Gatenby et al., 2009; Shuck, Rocco and Albornoz, 2010). How organizations can foster EE is central to much thinking, in particular the role of managers and leaders. ‘Engaging leaders’ support adaptability, experimentation, learning and innovation (Alimo-Metcalfe et al., 2008). Managers demonstrate a facilitative and empowering style through listening, providing feedback, and offering support and recognition for effort (Macleod and Clarke, 2009).

L&D processes and practices are seen as important contributors to engagement, and there has been an emerging interest in the relationship between EE and L&D. In part EE is seen as significant from an L&D perspective because support for learning, training and development forms a key part of practices claimed to facilitate engagement. Training and development interventions such as coaching and mentoring, support for personal and professional development, opportunities for skills development, management development programmes, and support for communities of practice are all cited as important contributors to EE (e.g. Robinson et al. 2007; Seijts and Crim 2006).

Despite its widespread popularity, EE is a contested concept, subject to competing interpretations. Definitions of engagement often overlap with other earlier constructs, such as commitment, motivation, burnout, empowerment and organizational citizenship behaviour (OCB). Measures of engagement and practices claimed to enhance engagement are widely promoted in the academic and practitioner literature, but many aspects are under-researched.

Within a health service context ‘modernization’ has seen a drive for improved performance, and the focus has been on the management of organizational culture and improving learning. There has been increasing interest in EE, and support for learning and workforce development and continuing professional development (CPD) is a key factor in many recent initiatives in the health sector, promoted by government, and professional bodies (Murphy, Cross, & McGuire, 2006; Sheaff & Pilgrim; 2006). The modern health care context is

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characterized by an environment of change and uncertainty, giving rise to a need for flexibility and innovation (Davies and Nutley, 2000). Sambrook notes an environment of 'rapid, discontinuous change, accompanied by new internal structures, such as strategic business units and service level agreements' (2001: 172).

The role of L&D and the theme of EE and learning are thus topical areas of organizational inquiry. Studies on L&D within the health service are however limited (Sambrook, 2006), and there have been few such studies on EE. Commenting on research on related areas in the NHS, Davies and Nutley (2000) and Sheaff and Pilgrim (2006) suggest that there is a need for empirical studies in this domain.

Project Methodology

The study case study organization, NHS Lothian, is an umbrella organization covering several local authority areas in the UK, which includes a range of health service provisions, including several hospitals, general practice (GP) and community medical services. The theme for this study arose out of an expressed senior management interest in finding out more about EE in the organization, in response to results of a staff attitude survey.

The study takes a social constructionist perspective to understanding organizational behaviour, which focuses on subjective consciousness, on the way people make sense of the world, especially through sharing experiences with others via the medium of language (Easterby-Smith, Thorpe, & Jackson, 2008). The research follows an iterative approach, the focus of the study and research questions evolving throughout the process of planning, data gathering and data analysis, moving between the literature and the data. A qualitative empirical study incorporates semi-structured interviews with health service L&D professionals, and 10 focus groups with 52 NHS Lothian staff. These were nurses and allied health professionals such as physiotherapists, radiographers and occupational therapists. Participants worked in a variety of clinical settings within NHS Lothian, in different institutions, and in the community. Three of the focus groups were held with administrative staff, including medical secretaries. A specific focus in this research was on listening to voices of staff. From a constructionist perspective the interview and focus group is a shared experience of creating meaning, or providing insight into multiple realities of the social world.

Transcript data was subjected to a thematic analysis, with use of computer aided qualitative data analysis software. An analytical coding frame was devised based on themes that had been determined out of the research questions, developed from the review of literature, and evolved during the data analysis. Thus codes emerged partly from studying the data, and partly from pre-determined focus around the research questions. Key themes emerged in three broad areas: views on employee engagement, the organization as a place to work, and learning and development.

Whilst it is not possible to generalize from a case study in the same sense as it might be from a more quantitative study, theoretical generalization is possible (Eisenhardt and Graebner, 2007). Payne and Williams (2005:296) argue that limited '*moderatum* generalizations' are possible from qualitative research methods. It is proposed that a number of findings have wider implications beyond the case organization, and these themes have been subject to a deep critical analysis with reflection informed by theory. In addition a range of issues emerge from the analysis which may be more specific to the organization, and which may be of interest to the wider research community from an illustrative perspective.

Structure of the thesis

The thesis chapters are as follows:

Chapter 2 explains the background to the study and the process of developing the research proposal. The rationale and purposes are outlined. The conceptual framework for the research is discussed. The processes of inductive, deductive and abductive reasoning are explored, providing an explanation for the development and modification of the research questions as the study emerged.

Chapter 3 provides a background to the organization, drawing on interviews and published documents. Key aspects of relevance to the study are examined, including HRD/L&D, organizational priorities, commitments, and challenges.

Chapter 4 reviews the extant literature, and examines the constructs of EE and of work engagement (WE), and related concepts such as motivation and commitment. It explores EE

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practices and the role of L&D in EE, and examines some of the claims and critiques made in the L&D/HRD and wider mainstream literature. It discusses the background to L&D in the NHS. It introduces a critical HRD perspective on EE, examining some underpinning assumptions, and perspectives on new public management in the NHS. EE is then examined as a discourse, discussing how the discourse ‘talks EE into being’, the discourse of cultural management, and how organizations operate with multiple and at times competing discourses.

Chapter 5 explains the methodology and the rationale for the approaches taken, including the approaches to data gathering and analysis. The underpinning theoretical stance is subject to critique, and theory examined to inform the research design and methods.

Chapter 6 reports and analyses the findings from the focus groups and interviews. This is presented in narrative and diagrammatic form, with extracts of dialogue and explanation and discussion.

Chapter 7 discusses the findings in the light of the review of literature and the documentary analysis. Significant themes which emerge are subject to discussion and analysis. The specific organizational and the wider practice and theoretical implications are discussed. The research questions are revisited.

Chapter 8 summarizes the conclusions and the contribution the thesis makes to knowledge. Recommendations for areas of further research are made, and there is a reflection on the limitations of the study.

The Appendices present evidence from the analysis of data, and relevant background documents used in the research.

The research and thesis writing followed the timetable:

Proposal preparation, submission and approval: November 2009 – April 2010

Fieldwork: Focus groups: April – August 2010. Interviews: January 2010 - 2012

Literature review, case study, data analysis, discussion and writing up followed an iterative process throughout the research period. Viva January 2014. Final submission February 2015.

Chapter 2. Research background, aims and conceptual framework

Introduction

In this section I will describe the process of developing the research proposal and summarize the aims and approaches taken to the research. I will discuss the conceptual framework underpinning the research.

Rationale – planning the research

The chosen focus and approach for this research, like most research projects in the social sciences, is determined by a mixture of theoretical considerations and practical factors. Cohen and Manion (2003) suggest that there are two phases in planning research – a divergent phase and convergent phase. The divergent phase opens up a range of possibilities, which are sifted through during the convergent phase. During my divergent phase, I initially made some inquiries with several colleagues working in NHS Lothian, a local health authority, explaining that I was interested in undertaking what I termed ‘an in-depth organizational study’ for my EdD thesis, and asked to meet up for an informal chat about current issues in their work, to investigate possibilities for a mutually beneficial research project.

The organization had recently launched a new Organization Development and Human Resource (OD/HR) strategy. A meeting with the Director of Human Resources and Organizational Development (HROD) in April 2009 highlighted some issues of concern for NHS Lothian around the theme of employee commitment and engagement, emerging out of the results of the 2008 NHS Scotland staff opinion survey, and a willingness to consider a research project in this area. Silverman (2011) advises caution in developing a research project on the basis of a ‘social problem’ that has been identified by practitioners or managers. He does not argue for rejecting such a starting point, suggesting that one should rather reject the commonplace definitions of a ‘social problem’, and that social science research can offer new perspectives on such ‘problems’. ‘Social’ or administrative ‘problems’ should be defined in terms of their historical, political and contextual sensitivity. This view was implicit in my choice of topic and informed my approach to the research.

An initial review of literature revealed EE to be an area of emerging significance in L&D research, and thus I moved into the 'convergent phase'. I developed an initial proposal for an exploratory study that would focus on staff experience around issues of EE and L&D within NHS Lothian. A formal request for access was submitted, which sought to address the concerns of key stakeholders in the project, and set clear boundaries on what could be expected from the research. My preference to take an interpretive approach determined a predominantly qualitative methodology to develop rich data, with the aim being to go beyond the presenting issues in the survey, to seek to develop a deeper understanding of staff perceptions. Staff experience of the 'drivers for' and 'barriers to' EE would be explored, with a focus on the implications for learning and development in the organization. It was envisaged that this would be an exploratory study, possibly developing an approach that could be rolled forward. After further negotiations I presented a revised proposal that was accepted.

Research approaches and paradigms

From an interpretivist perspective all aspects of the research process are mediated through the interpretations of the researcher, and their implicit or explicit pre-existing conceptual framework (Pidgeon & Henwood, 2009). Surfacing and scrutinizing one's internalized assumptions as a researcher and engaging in meta-theoretical reflection can lead to improved validity in knowledge claims (Tsoukas and Knudsen, 2003). Underpinning paradigms (sometimes referred to as models, or perspectives) will influence the research approaches to data gathering and analysis. Paradigms can be broadly distinguished by research which draws on the scientific method, and that with an interpretivist focus, a difference which has been described as one of measuring behaviours or finding meaning in behaviours (Maylor and Blackmon, 2005).

A scientific approach to data gathering is broadly characterized by asking questions that have been decided in advance, and a preference for quantification in the analysis. Anderson (2004), in common with many others, uses the term positivist rather than scientific. Positivism in organizational science seeks to create general theories about organizations and their members, in line with universal laws in the natural sciences (Donaldson, 2003).

In contrast, the goal of ethnographic or interpretive research is not to explain human behaviour so much as understand it (Maylor and Blackmon, 2005). Some eschew a simple

either/or view, suggesting that interpretivism is one epistemology falling within a continuum, at which positivism and 'subjectivism' form two extremes; within this continuum are realism, critical realism, interpretivism, and constructionism (Maylor and Blackmon, 2005). Positivism, realism and critical realism all exhibit an objectivist ontology, more associated with the scientific method, whilst interpretivism and constructionism are broadly subjectivist, and fall within an ethnographic approach (Maylor and Blackmon, 2005).

A social constructionist approach to understanding organizational behaviour is based on the assumption that reality is not objective and exterior, but is socially constructed and given meaning by people. Rather than a search for 'objective reality', it focuses on subjective consciousness; on the way people make sense of the world, especially through sharing experiences with others via the medium of language (Easterby-Smith et al., 2008). From a relativist position the social world is not composed of a single objective reality, but rather is composed of a series of multiple realities, each of which must be understood and taken into account (Remenyi et al., 1998: 35). Some tend to use the terms constructivism and social constructionism interchangeably, subsumed under the general term 'constructivism' (Andrews, 2012). The constructivist approach does not seek single, universal and lasting truth:

still, it remains realist because it addresses human *realities* and assumes the existence of real worlds. However, neither human realities nor real worlds are unidimensional. We act within and upon our realities and worlds and thus develop dialectical relations among what we do, think and feel. (Charmaz, 2003: 272).

This research project is influenced particularly by ethnomethodology, which 'shares naturalism's attention to detail but looks in detail at peoples' taken-for-granted ways of creating orderly social interaction' (Silverman, 2005: 98).

Management research tends to be dominated by the scientific model of research (Cohen & Manion, 1994), but social constructionist or phenomenological perspectives are being increasingly used for the study of behaviour in organizations (Remenyi et al., 1998). As noted, the distinction between the two perspectives can be less rigid. Donaldson argues that for modern positivism in organization science, 'thinking and feeling and other unobservable processes are accepted as existing and being legitimate topics of study, though

this must perforce be though their manifestation as observables, e.g. interview protocol or questionnaire response' (Donaldson, 2003: 51). Rorty (1994) suggests that it is misleading to consider that the quarrel between positivist ('objective', 'value-free', 'scientific') and hermeneutical approaches to social science research is simply one of method. Rather it is between the competing goals of 'explanation' and 'understanding' (Rorty, 1994: 51).

Burrell and Morgan (1979) identified four paradigms in sociological research (functionalist, interpretive, radical humanist and radical structuralist), and suggested initially that individual research paradigms were incommensurate. Denzin and Lincoln (2003) categorise four paradigms as positivist and postpositivist, contrasted with the constructivist and critical theory paradigms. (Lincoln et al. (2011) recently added a fifth paradigm to Denzin and Lincoln's earlier model, the participatory/cooperative paradigm, proposed by Heron and Reason (1997)). Contrasting ontologies and epistemologies have emerged in research, including for example, feminist theory, poststructural and postmodern work. There is contention between paradigms 'for legitimacy and intellectual and paradigmatic hegemony' (Lincoln et al., 2011: 97).

Lincoln et al. (2011) argue that rather than viewing paradigms as 'competing', what is significant is where paradigms exhibit confluence and differences. Research in practice does not usually adhere to idealized paradigms: 'Researchers are rarely idealistic paradigm warriors, but, more realistically, while they certainly do have certain paradigmatic predilections, they remain open to borrowing from other paradigms and perspectives as they see fit' (Tsoukas and Knudsen, 2003: 11). The researcher has been characterized as a bricoleur, 'a maker of quilts, or in filmmaking, a person who assembles images into montages' (Denzin and Lincoln, 2011:4). As Van Maanen (1988: 66) also argues, 'Fieldworkers are notorious analytic bricoleurs, sniffing out and sifting through current theory for leads as to how fieldwork materials might be conceptualized'. This perspective seems particularly apt for research in the field of HRD, and L&D in particular, a field that does not exhibit rigid boundaries, and draws from a range of disciplines.

Lincoln et al. (2011) suggest a position which is 'loosely in the constructionist camp', which has been helpful in positioning this research project. They suggest that the criteria for judging 'reality' or validity are not absolutist; 'rather they are derived from community consensus regarding what is "real"; what is useful and what has meaning (especially

meaning for action and further steps) within that community, as well as for that particular piece of research (Lincoln et al., 2011: 116). Much social phenomena consists of the ‘meaning-making activities of groups and individuals’ (Lincoln et al., 2011: 116).

Research objectives

The scientific approach of deduction requires the researcher to collect data to test theory, proceeding in a logical, structured manner, and research questions emerge from the literature review, informed by theory (Maylor and Blackmon, 2005). The research question ‘is assumed to be absolutely clearly stated and concisely worded’ at the outset, and the research is built around the research questions (Lee, 2002: 21).

In contrast, in an ethnographic approach the study is more open-ended and emergent. An inductive approach requires the researcher to collect data to generate explanations and theory. Data is analysed to identify patterns, and the researcher can generalize these patterns as a conceptual framework to create new insights, in a process of theory building. Whilst the aim of a scientific approach is to seek out general laws or patterns, ‘ethnographers try to uncover meaning in a specific situation by studying it intensively. The *depth* is characteristic of ethnographic research’ (Maylor and Blackmon, 2005: 146). Some starting point is needed, but a detailed literature review is not necessarily made at start of the research process; it may also serve to help make sense of the emerging data. ‘Ethnographers start not knowing exactly what they might find out or even how they might get there. Much of the learning will emerge along the way and from the journey itself’ (Maylor and Blackmon, 2005: 144).

Anderson (2004) notes some criticism of such an interpretivist approach, in which issues are explored rather than tested against a pre-determined hypothesis. Lack of a clear focus at the outset can result in loss of direction in the research, and to collection of a huge volume of data and no clear idea of what to do with it.

Inductive, deductive and abductive reasoning

The contrast between inductive reasoning and a more structured, deductive reasoning is sometimes used to distinguish between qualitative and quantitative research. Gibbs (2011) suggests that in fact most qualitative analysis is both concept driven (deductive) and data

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driven (inductive). That is, it starts from some theoretical ideas, derived from the literature, research brief/questions, and/or interview schedule, and it also aims to discover new ideas, theories, and explanations in the data. Sinkovics & Alfoldi (2010: 114) suggest that ‘in essence, the debate between these opposing views is a debate about the relative importance of creativity versus formalization, of meaning versus validity’.

A third process of abductive reasoning involves an interpretive stance which is neither inductive nor deductive. Abduction, or hypothetical inference, is the process of initiating theory through creative insights. ‘Abduction begins by recognizing an anomaly or breakdown in our understanding of the world, and proceeds to create a hypothetical inference that dissolves the anomaly by providing a coherent resolution to the problem (Van De Ven, 2007: 98).

Van de Ven argues that three activities are involved in theory building, which requires all three types of reasoning, in an iterative cycle. The first, conceiving or elaborating a theory, involves abduction; the second, constructing or elaborating the theory, involves logical deduction; and the third, justifying or evaluating a theory, involves inductive reasoning (Van De Ven, 2007:101). Gummesson (2000) argues that after the initial stages all types of research becomes abductive - the iteration between the inductive and the deductive.

The research process can be described as one of seeking patterns in the data through understanding of theory:

Induction has its point of departure in empirical data and deduction in theory. Abduction starts from an empirical basis, just like induction, but does not reject theoretical preconceptions and is in that respect closer to induction. The analysis of the empirical fact(s) may very well be combined with, or preceded by, studies of previous theory in the literature; not as a mechanical application on single cases but as a source of inspiration for the discovery of patterns that bring understanding. The research process, therefore, alternates between (previous) theory and empirical facts whereby both are successively reinterpreted in the light of each other. (Alvesson and Sköldberg, 2009: 4)

An approach incorporating abduction approach is emergent and flexible. It can start with a knowledge of the theory and literature in the area of study, to enable one to identify significant themes that emerge and place them within the current literature, or be confident when it seems that new insights might have emerged. Projects are embedded in ‘background and disciplinary knowledges’ (Pidgeon & Henwood, 2009: 633-4).

Research questions

Cohen and Manion (2003: 75) suggest that in order to operationalize the research you need to translate a 'very general research aim or purpose into specific, concrete questions to which specific, concrete answers can be given'. Anderson (2004) suggests that setting broad research objectives can avoid common problems associated with research questions, for example the temptation to formulate questions you already know the answer to, which merely serve to reinforce existing assumptions.

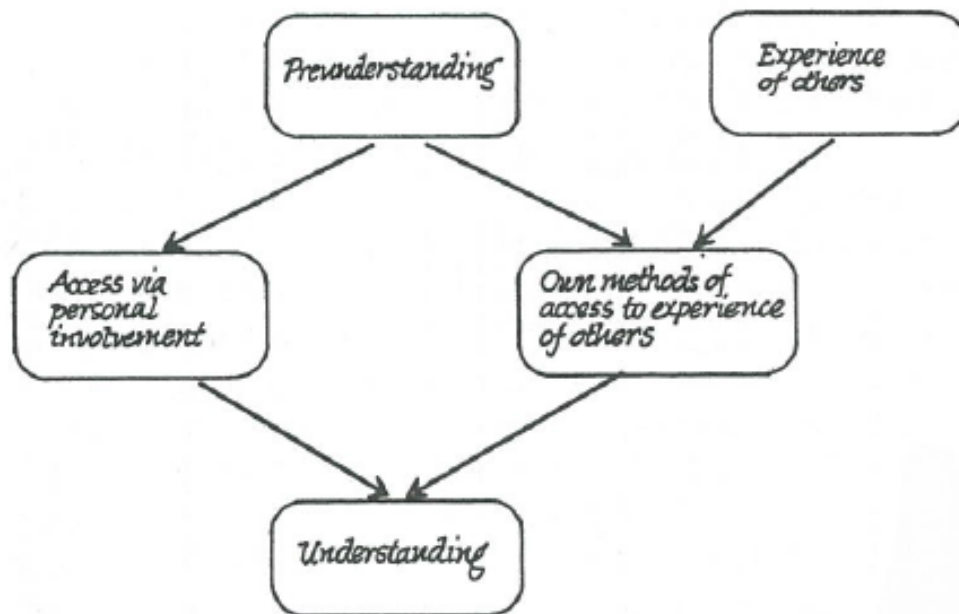
In contrast to a linear plan in which the research questions form the starting point to the research, the initial research questions can be regarded as 'prima facie' questions, but that '*it is to be expected* that this (or these) will not be your final question(s)' (italics in original); these initial questions will be gradually refined in what is a '*recursive or iterative*' approach (Thomas, 2013: 18-19). Easterby-Smith et al. contend that 'the whole research project may be seen as a continuous process of focusing and refocusing' (2008: 24). Lee suggests that in a sense 'the "research" *becomes* the search for the "research question"' (2002: 24). Lee argues that the supposed linear progression of much research is actually a post-hoc result of writing up – for most social science research the process is actually much more roundabout.

It seems to me that in the phenomenological approach, as well as the scientific, there are two sorts of research question. One that gets written up neatly as if it were the precursor to the research, and the other that messily and slowly emerges from primary (empirical) and secondary (literature etc.) data as the real 'research' (the making sense of the area) is conducted. (Lee, 2002: 24).

One way of viewing this process is suggested by Gummesson (2000), who highlights the research process as a movement from 'preunderstanding' to 'understanding'.

'*Preunderstanding*' refers to things such as people's knowledge, insights, and experience before they engage in a research program or consulting assignment; *understanding* refers to their improved insights emerging during the program or assignment' (Gummesson, 2000:57). Preunderstandings are more than simply knowledge but also imply attitude and commitments. Figure 1 illustrates the how preunderstanding moves towards understanding through personal insights and gathering the experience of others, e.g. by empirical research such as interviews.

Figure 1 Sources for Understanding (Gummesson 2000:71)



Gummesson (2000:70) introduces the notion of the 'hermeneutic spiral' to describe the research process, 'an iterative process whereby each stage of our research provides us with knowledge; in other words, we take a different level of preunderstanding to each stage of the research'. New understandings serve as preunderstandings to further cycles of inquiry.

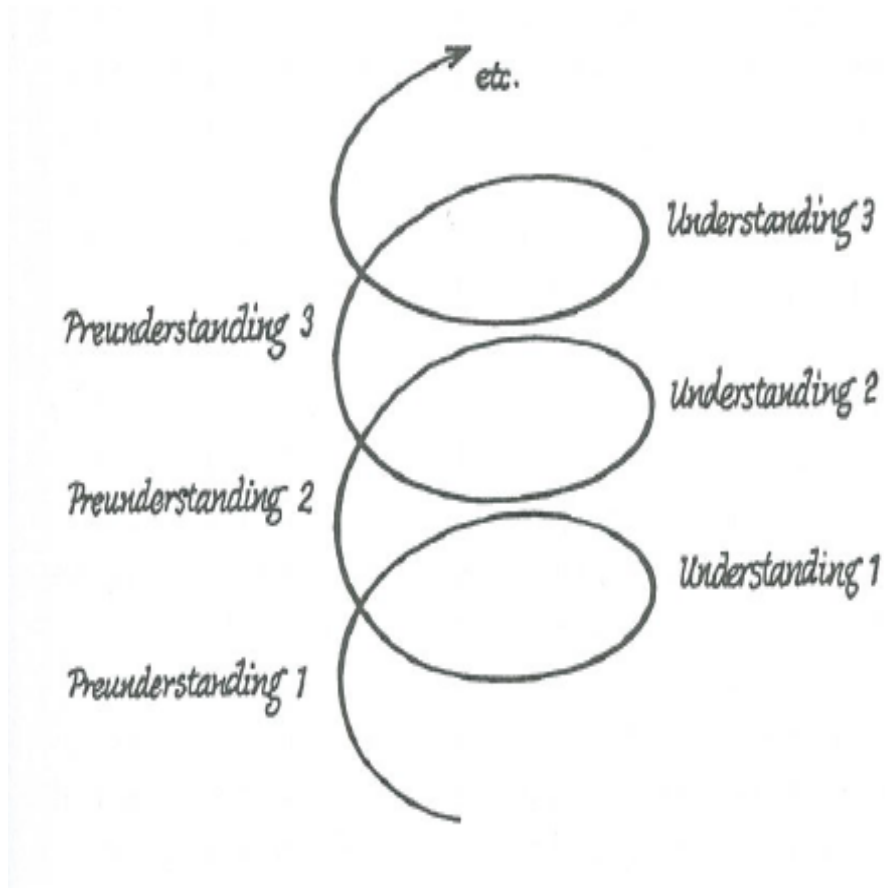


Figure 2 The Hermeneutic Spiral (Gummesson 2000:71)

Gummesson's (2000) hermeneutic spiral provides a useful model to illustrate the iterative process of a research project. As noted, insights can be gained through inductive, deductive and abductive reasoning. Preunderstandings move towards understandings, in cycles of reasoning and data gathering. This describes the process taken for this study.

This research study as initially conceived was based around four research questions:

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1. Is the concept of employee engagement used in a Health Service context? If so, what are the meanings and purposes of the concept of employee engagement in a health service context?
2. What are the drivers for and barriers to employee engagement in NHS Lothian?
3. Do formal and informal learning processes have a role in contributing to employee engagement?
4. If so, how can organizations develop support for formal and informal learning process to contribute to employee engagement?

Following an initial review of literature and clarification of the research objectives, an in-depth critical review of literature was undertaken. This informed the design of the empirical research and influenced the categories for data analysis. Following on from the fieldwork, themes emerging from the analysis of findings prompted further reviews of literature, in an iterative process, cycling between the data and the literature. A further cycle of data gathering and analysis led to some modification of the initial research questions, which sought to provide a focus on the emerging theoretical analysis of EE in the healthcare setting, and the possible wider implications of the findings. The modified research questions which the final thesis seeks to address are:

1. What meanings, purposes, attitudes and behaviours are attached to the concept of employee engagement in a given health service setting?
2. What factors act as drivers for and barriers to employee engagement in this setting?
3. What key learning and development themes contribute to employee engagement in this setting?
4. How can we conceptualize employee engagement within a health service context?

Revised RQ1 is essentially similar but provides a broader focus more suited to the construct of EE.

Revised RQ2 is also similar but with a more specific focus on factors acting as drivers and barriers.

Revised RQ3 provides a broader focus on L&D and its contribution to EE, and not specifically focussing on learning processes.

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Revised RQ4 provides an opportunity to reflect on key themes arising out of the study that may have wider implications. It retains the focus on the health service context, and also on the broader construct of EE rather than the focus on learning processes.

Following Gummesson (2000), figure 3 (3.1, 3.2, 3.3) overleaf provides a visual model of the research process for this study.

Figure 3.1 Thesis Conceptual Map Stage 1

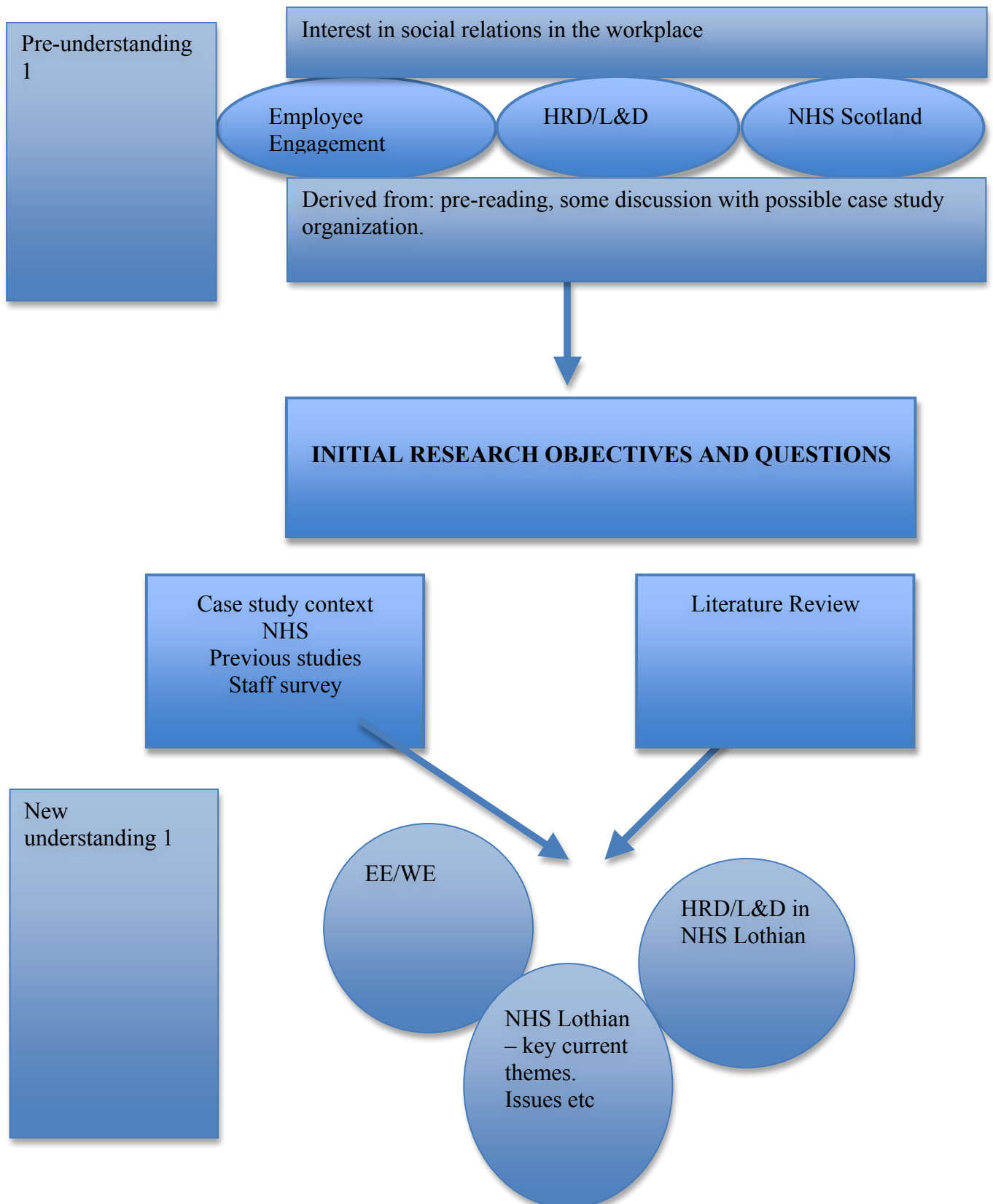


Figure 3.2 Thesis Conceptual Map Stage 2

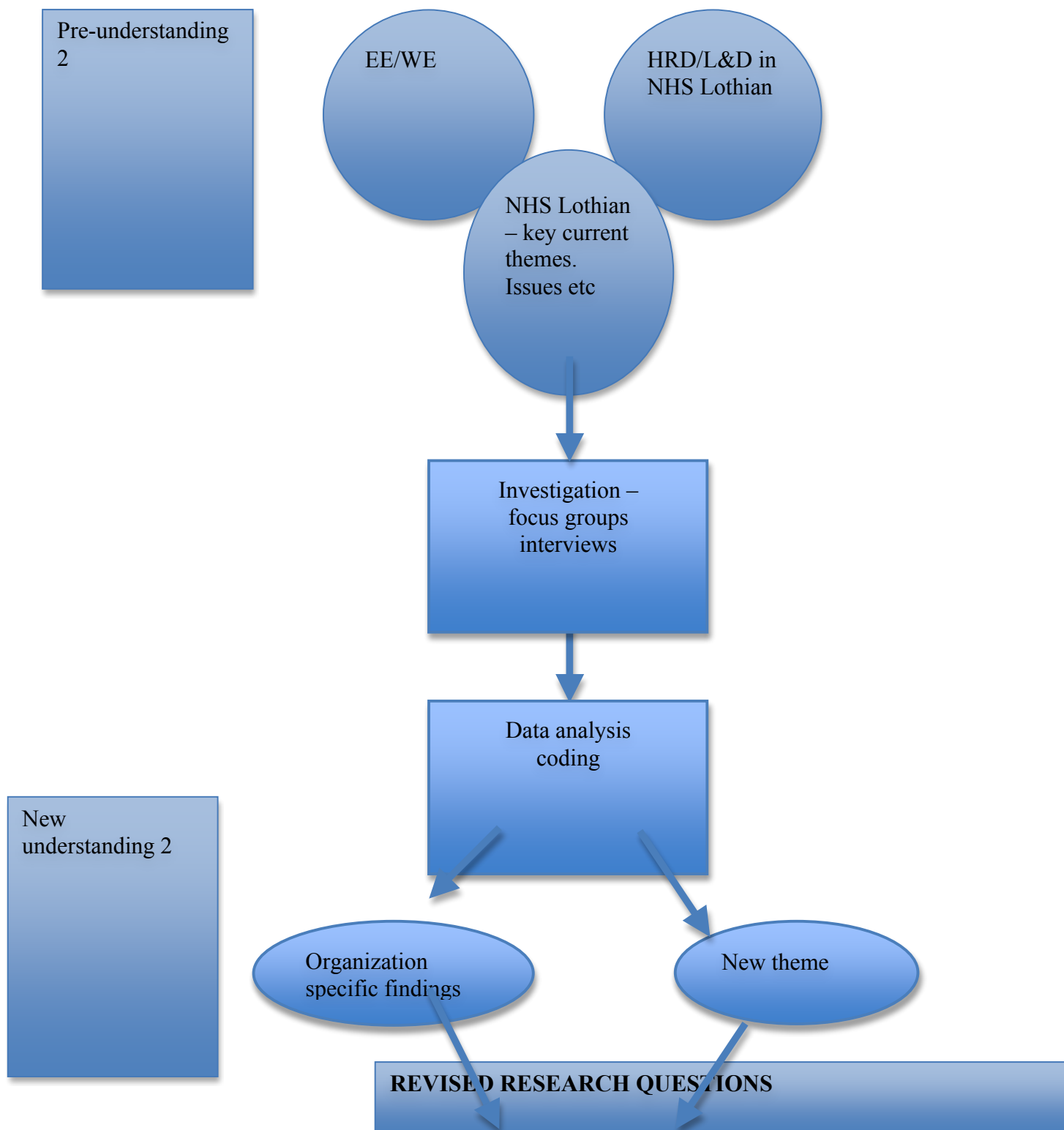
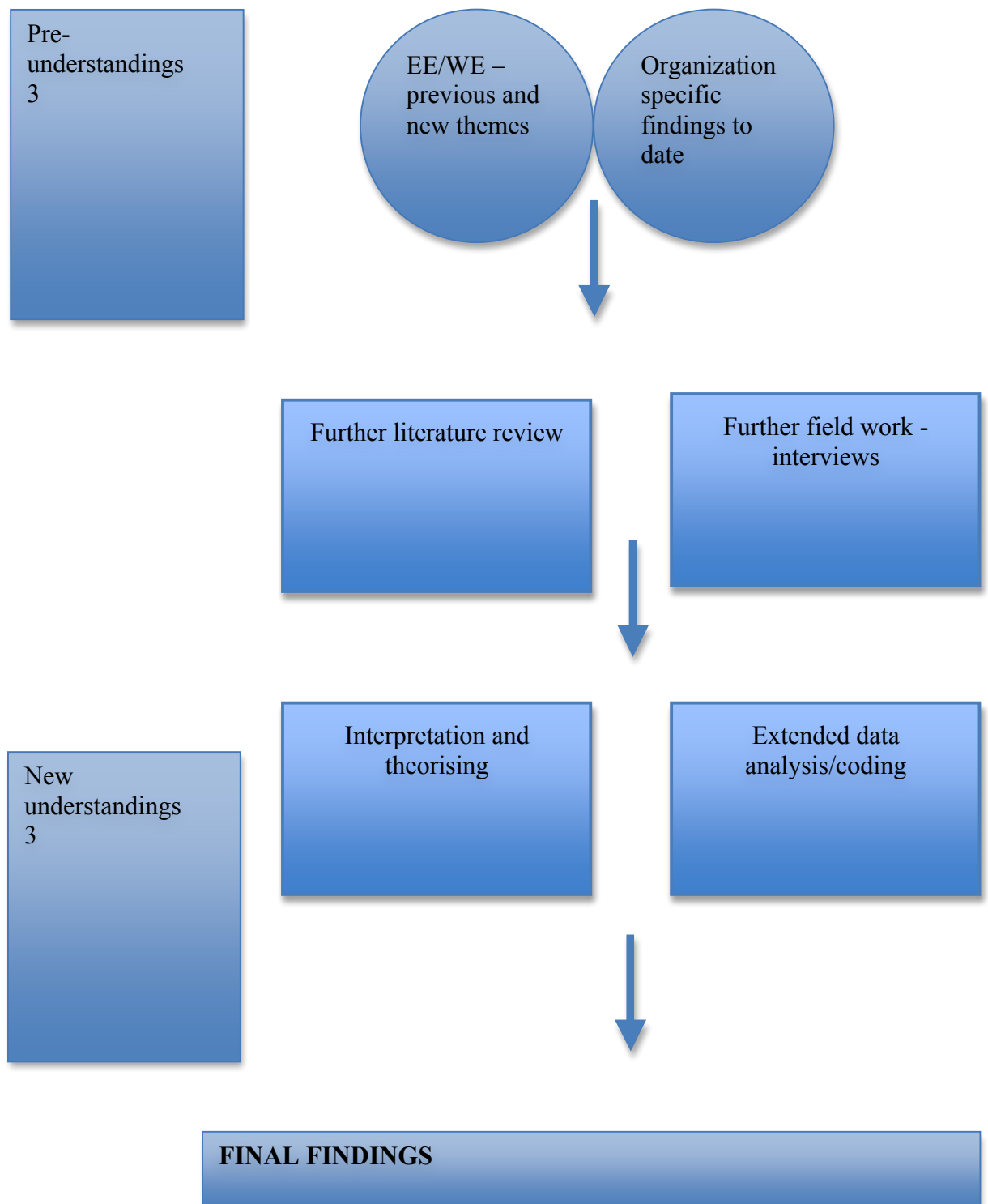


Figure 3.3 Thesis Conceptual Map Stage 3



Conclusion

Having explored the conceptual framework underpinning the approach to the research, the next chapter describes the case organization in more detail, and examines themes relevant to the scope of the study.

Chapter 3 The Case Organization NHS Lothian.

Introduction

This chapter provides an overview of the case organization, NHS Lothian. The information for this chapter was obtained from interviews and from available documents. The methodology chapter explains further how the documents were obtained. I sought to deepen understanding of the research context, both organizational and sectoral, by attendance at a range of relevant events (e.g. NHS Scotland Annual Event, NHS Lothian Board Meetings, other meetings and events by arrangement); by consulting published documents (E.g. NHS Lothian Key Documents); and by interviews with a range of key informants, in particular those with an HR and L&D focus.

NHS Lothian

NHS Lothian is a large public health organization in Scotland, serving a residential population of around 800,000 people. It provides a comprehensive range of primary, community-based and acute hospital services. It also provides a range of country-wide specialist services, including liver and kidney transplantation, neo-natal intensive care, cancer services and complex surgery. It has a budget of around £1.6 billion. It is a major employer in the region, employing approximately 24,000 staff in 20 hospitals and over 300 Health/Medical centres. It is linked to University of Edinburgh Medical School.

NHS Lothian was established in 2001 as the ‘umbrella’ organization for all health services operating within the four local authority areas. A unified health board, Lothian NHS Board, was tasked with merging the former health authority, Lothian Health, and the region’s three former NHS Trusts – Lothian University Hospitals, Lothian Primary Care, and West Lothian Healthcare. The three trusts were dissolved in 2003-04 with the aim to provide a ‘single system’ model of working. The organization is engaged in an ongoing programme of ‘modernisation’, which it argues will create a more streamlined, patient-centred structure and a more integrated approach to planning and delivering health care. This is part of an ongoing productivity and efficiency programme, common to all health authorities in the UK.

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The organization faces a range of general and specific challenges. General challenges are implicit in the nature of health care management and delivery. These include the impact of changing population demographics; advances in medical technology and pharmaceutical developments; and changes initiated by central government. The NHS in Scotland is facing major change in several areas. There is a move to more community based and partnership working, with an emphasis on working and thinking innovatively – e.g. using new technology such as remote monitoring. The UK government's drive to reduce the deficit has led to tighter budgets, recruitment freezes and job cuts (although currently there is a commitment to no compulsory redundancies). There has been no increase in money from central government, and a commitment to savings – 5% year on year, with a 25% cut in senior management. (The Health Service currently takes up 60% of the Scottish parliament budget).

A national initiative for which all NHS Boards are accountable to the Scottish Government for is achieving HEAT targets. HEAT stands for Health improvement, Efficiency, Access to services and Treatment. It is an internal NHS performance management system that includes targets that support National Outcomes.

Some specific challenges for NHS Lothian include infrastructure developments, such as a planned life science park for 8000 people to be built within the site of a recently opened new Royal Infirmary; a new children's hospital; and relocation of a local mental health hospital. The aim is to have them all on the new Royal Infirmary site, which will grow from 8000-30,000 over a ten-year period. Other challenges are a process of service and role re-design, and a variety of initiatives and strategies targeted at different patient groups and services.

As noted in the NHS Lothian Workforce Plan April 2006, 'the NHS in Scotland is going through radical change of a scale greater than it has experienced before. The drivers for change are numerous and complex and all have a profound effect upon NHS Scotland's key asset – its workforce' (NHS Lothian Workforce Plan April 2006: 19).

Staffing

As of March 2012* NHS Lothian utilised 18,686 whole time equivalent staff at an approximate cost of £770m per year in direct workforce costs. The workforce is 76% female

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and 24% male, but there are significant differences within the workforce. Emergency services and the Board are predominantly male, whilst the medical workforce is split approximately 50/50. The overall skill mix within the workforce (excluding medical staff) is relatively balanced in the higher band workforce, but there are fewer opportunities for workers in the lower bands.

NHS Lothian Workforce by operating division- March 2012 (WTE):	
Acute division	57%
Corporate and facilities	22%
Central CHP	9%
West Lothian CHP	5%
Midlothian CHP	4%
East Lothian CHP	3%

NHS Lothian Workforce by job family- March 2012 (18,686 WTE):	
Nursing and midwifery	48%
Administrative services	15%
Support services	11%
Medical	10%
Allied health professions	7%
Healthcare sciences	4%
Other therapeutic	3%
Executive	1%
Medical and dental support	1%
Prison	0%
Personal and social care	0%

NHS Lothian Workforce expenditure by job family – March 2012 (£770m)	
Nursing and midwifery	43%
Medical	24%
Administrative services	9%
Support services	7%
Allied health professions	7%
Healthcare sciences	4%
Other therapeutic	3%
Executive	1.6%
Medical and dental support	1%
Prison	0.2%
Personal and social care	0.4%

Table 1, 2, 3 NHS Lothian Workforce

*These figures are taken from March 2012 so are not an exact comparison with the figures from the time that the fieldwork was conducted in 2010-11. However there have been no significant variations due to the freeze on recruitment and budget restrictions.

Human Resource management and development

There are a range of challenges associated with human resource management and development and delivering learning, training and development opportunities.

Online literature about NHS Lothian in the website section on 'Working with us' stresses that staff are the most valuable resource. 'Without their expertise, enthusiasm and commitment to care, NHS Lothian could not provide the standard and quality of care patients require (Working with us web pages).

The organization argues that 'working in partnership with staff is a strong theme in NHS Lothian, as we value our workforce and are keen to utilize the talent we have' (Board paper, 26 May 2010: 5). One stated goal is to be an exemplar employer. The organization aims to:

- '-be an employer of choice and work in partnership with our staff
- improve productivity and quality while reducing cost' (Board paper, 26 May 2010: 5).

The Agenda for Change is an initiative focused on the whole NHS workforce of 140,000 people in Scotland. It includes assimilation to new grading structures based on a knowledge and skills framework. Job Evaluation (JE) is used to enable jobs to be matched to national job profiles, or allow health boards to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit. The aim is for the pay system to

- deliver fair pay for non-medical staff based on the principle of 'equal pay for work of equal value'
- provide better links between pay and career progression using the Knowledge and Skills Framework
- harmonise terms and conditions of service such as annual leave, hours and sick pay, and work done in 'unsocial hours'

'Training and continuing education and development of our workforce is key to future success' (Planning for the future: NHS Lothian's 5-year plan 2009-2014 Board paper, 26 May 2010:9). The HR/OD Strategy (2010) notes that appropriate training and development will be provided to support Engaging leadership. A coaching plan for staff will be introduced, and staff development geared towards developing person-centred, compassionate care.

A development programme for succession planning for leaders will also begin. There is a three-module skills development programme:

LEAN programme. Focuses on the removal of waste.

Change Acceleration Process, which provides tools and techniques to lead a team through change.

WorkOut which provides a structured way to problem solve and develop solutions.

A Skills Maximisation Toolkit (NES, 2010) set out a process for reviewing patient journeys and the roles that different members of the allied healthcare team could and should undertake. There are also significant demographic issues within the NHS meaning that many of the ‘talented’ with specialist skills are set to retire, for example 30% of NHS Lothian's senior managers are aged 55 – 59.

Key HRD challenges include reshaping of medical training and working hours, the ageing workforce, and people working less than full time (Board paper 26 May 2010:8). More detail on the L&D initiatives is discussed in the chapter on findings.

A three-year organization development/ HRD strategy was launched in 2009, which is relevant to the timing of the fieldwork for this research. The HR Strategy emphasises that ‘staff are our main asset’ and the strategy puts an emphasis on Living Values, Engaging Leadership and Delivering Quality. Training and continuing education of ‘our workforce’ is seen to be a key to future success (2010).

The 2008 staff survey, which led to the idea of researching EE, covered the NHS in Scotland, and was completed by 28% of NHS Lothian staff, a total of 6000 people. It looked at attitudinal, behavioural, and cultural issues. A report providing an analysis of the 2008 staff survey data was presented to the NHS Lothian Board (May 2009). An action plan was then agreed with the Lothian Partnership Forum and an annual progress report is brought to the Board each November (NHS Lothian Staff Survey 2008 – update). A paper to the Board meeting 25 Nov. 2009 notes that there were ‘issues around how NHS Lothian appeared to manage change, communication issues between managers and staff and also concerns that the issues identified in the survey would not be addressed.’ Concerns that had been raised in previous surveys included stress at work and bullying and harassment. These had already been addressed in the 2008 HR&OD strategy.

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A further survey was carried out in 2010, after the main fieldwork for this research. In a report on the NHS Scotland 2010 staff survey, Bacon and Hoque (2010) note that ‘Staff responding to the 2010 survey demonstrate higher levels of employee engagement than staff responding to the 2008 survey. Both the 2008 and 2010 survey included identical measures of employee engagement. ‘These questions assess the degree of commitment employees feel towards NHS Scotland and the discretionary effort that employees feel they are prepared to put into their work’ (Bacon and Hoque, 2010: 20).

Staff governance.

NHS Scotland Staff Governance Standards set out a national commitment towards working with staff, and NHS Lothian is bound by this national framework (Bowles et al 2012). Each health board in Scotland is required to have an annual Staff Governance Action Plan. Staff Governance is defined as ‘ a system of corporate accountability for the fair and effective management of all staff’.

The Standard requires that all NHS Boards must demonstrate that staff are:
well informed
appropriately trained
involved in decisions which affect them
treated fairly and consistently, and
provided with an improved and safe working environment
(Staff Governance Standard for NHS Scotland employees 2007: 4).

NHS Lothian states that it is committed to engaging staff as key partners in service planning and modernisation through a Staff Partnership Framework. Actions included a guidance plan for managers on managing change, a review of internal communications, leadership and management development programmes (NHS Lothian Staff Survey 2008 – update Board meeting, 25 Nov. 2009).

The ‘Lothian Way’

The ‘Lothian Way’ is a culture change programme with the aim being to promote excellent patient service.

The programme will create a patient (and healthcare-community)- focused environment through the culture, values and behaviours consistently being adopted and the management style, which will enable, encourage and facilitate excellence in the delivery of our services.
(NHS Lothian meeting paper, Sept 2005).

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The Lothian Way themes, to which all staff are asked to work are:

Person centeredness:

Putting people at the heart of everything we do

Being sensitive to individuals' needs and providing the right service at the right time in the right place

Partnership:

Working in partnership with staff, patients, the public and other agencies to provide the best possible service

Being inclusive, involving patients and local people in decisions of their own healthcare

Integrity

Respecting people as individuals and treating them with courtesy and dignity. Communicating openly and honestly: with each other and the public

Accountability

Doing what we say we'll do.

Taking responsibility as an individual and an organization for our actions and decisions

Innovation

Taking changing needs into consideration and developing a culture of continuous improvement to deliver a service that exceeds expectation.

Leading by example, setting high standards in our work and empowering others to do the same.

(Five year plan 2010).

Investors in people

NHS Lothian is one of the largest organizations to have received full accreditation to

Investors in People (IIP) 'Standard' level. Key components of the assessment include people strategy, leadership and management strategy, L&D, and empowerment. There is a new staff engagement policy, which involves workshop sessions, a new communications plan aiming to increase morale, and communication improvements (Annual review 2012).

There are 26 business units in the organization. Some have IIP, and some have ISO accreditation. Managers have been mandated regarding IIP, and there is a management development programme for senior staff. A formal training needs analysis is being conducted across the functions as part of IIP. The IIP framework provides for gathering of evidence around 10 indicators. There is a 4% sampling by an external assessor, of which there are six.

Postscript

The newer HR&OD strategy (2011-2014) set out in November 2011 includes measures to address future skills shortages. It includes a review of internal arrangements in training and development to enhance literacy and numeracy level of staff. It also aims to create a job infrastructure for lower level bands of staff so that staff have realistic promotion opportunities to advance their careers based on ability and ambition. The goal is to work with Higher Education and regulatory bodies to create an environment whereby a combination of the accreditation of experiential learning and study will give staff in bands 1-4 a route into the registered workforce thereby opening up opportunities for work at band 5 and above, and opening up an additional source of recruitment that will enrich the diversity of the workforce.

After a period of central government enforced non-recruitment, in 2012 NHS Lothian announced an increase to its clinical workforce equivalent to 250 whole-time posts, within theatres and a number of surgical specialities with the aim of reducing waiting times.

Review of management culture

Following concerns about compliance with implementation of waiting list targets in NHS Lothian, a team of consultants were commissioned to carry out a review of waiting time management, which was published in a report in March 2012. As well as highlighting issues to do with waiting lists, the report identified concerns about organizational culture, and allegedly unacceptable pressures being placed on staff. Reference was made to inappropriate and oppressive management styles. It found evidence of intimidation and inappropriate behaviours, and that bullying was 'common' at certain levels in the organization (NHS Lothian report 11/05/2012, BBC news 11/05/2012).

At the request of the Scottish Government Health Secretary an independent review into the management culture of NHS Lothian was carried out. The review included 57 structured on-to-one interviews and five focus groups with another 56 staff from a cross section of roles and disciplines. It reviewed existing data such as existing policies, a recent report from IIP, and NHS Scotland Staff survey 2010 data. The report, published in May 2012 (Bowles et al.,

2012), highlights an inappropriate management culture at the board, originating from the top level. There was a strong sense of a 'blame culture'.

Although the research and findings for this report came after the period of research for this thesis, it provides a relevant background on which to reflect on my findings, which used a similar approach of focus groups, and whose findings pre-date some of the concerns emerging from this later study.

The report found that the style and nature of accountability for staff performance within NHS Lothian has:

been at the expense of developing strong team working,
allegedly breached the Board's Dignity at Work Policy,
as a consequence created a blame culture.

Taken together they have combined to create an organizational culture where:
Bad news is not passed up the line,
a gloss is put on reports,
staff are told to 'just fix it' without support.

The organizational problems have been exacerbated as:
The culture has lasted for some time,
Some staff allegedly emulated inappropriate management styles,
Staff have not the used the Board's whistle-blowing and other procedures to raise concerns,
apparently for a number of reasons including lack of confidence in their application at senior level and
concerns about reprisals' (Bowles et al., 2012: 6).

Following on from the report, the Chief Executive resigned after more than a decade in the post.

The report makes recommendations on improving the board's values, culture and organizational development. It is not a general condemnation of management within the organization, and cites evidence of excellent relationships with teams, and many exceptionally good leaders.

In the one-to-one discussions and Focus Groups we found a highly dedicated and committed workforce with huge loyalty to the NHS and to NHS Lothian (Bowles et al., 2012: 11)

The 2012 report found what it termed a disturbing picture of the culture in some parts, where the objective of holding people to account is delivered in a manner that is questionable. Bullying is common at certain levels, and there is a blame culture. 'An undermining, intimidating, demeaning, threatening and hostile working environment for some staff' (Bowles et al., 2012: 22).

24 areas were the subject of an assessment and a report by IIP in April 2011. This report was mainly positive but some concerns were highlighted. There was a strong focus on targets, sometimes at the expense of a focus on people. Some managers used transactional rather than transforming styles, and some respondents used the word ‘bullying’ when describing management styles. The report suggests that there is a need to review and evaluate leadership and management development processes (Bowles et al., 2012: 11).

Bowles et al make a number of comments relevant to the theme of employee engagement.

‘In our review we have observed that although staff and managers are by and large committed to their team the broader engagement with NHS Lothian as an organization needs further work. The participation rates in the Staff Survey indicate a low engagement rating. Ensuring that developing positive engagement activity is a key strand of the updated HR and OD Strategy, linking this with pan Scotland and best organizational benchmarking will begin to measure improvement in staff engagement’ (Bowles et al., 2012:)

The report came up with a range of recommendations under headings:

- Change of leadership style
- Values culture and organizational development
- Re-establishing trust and confidence
- Performances management, targets and accountably
- Embedding policies
- Risk and reputation
- Mapping the future

This chapter has set the empirical context for the study, and the previous chapter discussed the conceptual framework. This provides a basis for the review of literature which follows, setting the scene for the following discussion on the methodology, presentation and analysis of data, and discussion and conclusions.

Chapter 4 Literature review.

Introduction

Employee engagement (EE) is a concept that has gained popularity in recent years in the drive to focus on high performance working. Engagement comes within the range of approaches to develop a strategic focus to human resource management (HRM) through human capital management, including such themes as talent management, employee commitment, and employer branding (Higgs, 2006). There is still considerable debate around EE; for example, is it a vital new concept for the future of business, or simply a reworking of familiar concepts such as commitment and motivation? One argument suggests that it is poorly conceptualized and has gained popularity with little empirical evidence of its validity. Despite its popular adoption, L&D theorists have been slow to mount the EE bandwagon (Shuck and Wollard, 2010); however there is now an emerging interest in EE from an L&D perspective.

Themes such as EE have been addressed in both the academic and practitioner literatures. The descriptive or prescriptive focus of much ‘popular’ or ‘practitioner focused’ literature frequently result in significant claims which are not necessarily borne out by research; however they may contribute examples which are less evident in more theoretically focused papers. Significantly, both sources, along with published policy documents, contribute to the development of the discourse of EE. With this in mind, this review will seek to identify the theoretical and empirical starting points of the construct of EE, and outline the context, history, and current utilization, exploring paradigms, and identifying and examining the taken-for-granted assumptions underpinning practice, and the claims made for such practices in academic, policy and popular texts. Theoretical critique will form the basis for the empirical study.

The term HRD is often used as an overarching concept incorporating L&D; however in practice and academic contexts the two terms are often used interchangeably. Within the case study context the term L&D was most familiar. However much of the academic literature uses the term HRD. For the purpose of this review of literature the term HRD is generally used, except where authors themselves use the term L&D.

The chapter will draw on emerging literature on EE, and unlike some earlier work from an HRD perspective (e.g. Shuck and Wollard, 2010), will draw on research into ‘work engagement’ (WE), and also on related aspects such as motivation, commitment, leadership and team development. The chapter first looks at how engagement is described and the arguments as to its significance for organizations, and examines common practices that claim to facilitate engagement, drawing out a number of controversies from research in business, management and psychology. The chapter goes on to discuss EE and HRD, concluding that HRD may be an inherent ‘driver’ of engagement. It then examines some of the antecedent concepts such as motivation and commitment, suggesting that there is much in research in these areas that has not been surpassed by more recent claims for EE. The chapter goes on to discuss work on the ‘locus of engagement’, examining evidence that people may be more engaged with their work group than with the organization as a whole, and the implications particularly for HRD.

The chapter then goes on to examine L&D and EE in the context of the NHS. It then introduces a critical management perspective, and goes on to explore EE from a discourse perspective. New public management is examined from the perspective of discourses and identity, and the notion of discursive struggle is explored.

Approach taken to the review of literature

The review of literature encompasses areas that are key to the scope of the study. HRD is essentially an interdisciplinary field of study (Stewart, 2005) and as such literature was drawn from a range of disciplines potentially including but not limited to sociology and psychology, and areas of professional practice, especially HRD, management, organization studies, HRM and HRD. In addition, the organizational context of the study, the NHS, suggests a further dimension of study in the fields of health care management and development.

The literature review was conducted by key word searches using ‘Searcher’, a meta database on the University of Edinburgh online library site. Use was also made of Google Scholar, and key word searches within a range of relevant journals. Article reference lists were also followed up, and searches for work by particular authors. As some sources are practitioner or policy documents, ‘grey literature’, terms were also entered into Google. Terms such as

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‘employee engagement’, ‘work engagement’ and ‘work motivation’ were used, and also combined with terms such as ‘HRD’, ‘learning and development’, and ‘NHS’. A wide range of search terms was used, and a snowball approach to identifying resources. Most of the literature was available online, such as academic journals and reports, but some books and published research papers were also consulted.

The notion of ‘theoretical saturation’ informed the literature search. There is a very wide range of literature on the topic – typing ‘employee engagement’ in the Google search engine got 48 million results, and 20,000 results in Google Scholar (4 April 2014). I endeavoured to identify all the articles on the topic of EE within the main HRD journals, such as *Advances in Developing Human Resources*, *Human Resource Development Quarterly*, *Human Resource Development Review*, *Human Resource Development International* and *European Journal of Training and Development*. I sought to identify which researchers were ‘key thinkers’ on EE and WE in the HRD field and also the wider HR and psychology literatures, as well as ‘new names’ who contributed varying perspectives on the topics. In assessing the contribution of literature, I was particularly interested in that work which exhibited theoretical rigour rather than evaluating empirical findings or research methods. I continued researching the literature throughout the period of the study, in particular a second review of literature to inform the analysis of the empirical data, as indicated in the thesis conceptual spiral models 1 and 2 (Figure 3).

Table 4 summarises key literature review terms, concepts and themes.

Employee and work engagement	Detail
Domains and literatures	Journals: HRD, Management Studies, Organizational Learning, HRM, Sociology of work. Work psychology Books: Management studies, 'Popular' literature. Reports: Government, Professional bodies, Consultancies Websites – Consultancies, Government agencies, Professional bodies
Concepts and constructs	Definitions, History, Scope Claims made Practices Employee Experience Drivers and Barriers Leadership and Management Disengagement Contexts of Engagement Locus of engagement Teams and work groups Training, Development and learning HRD Practices Scope for HRD and EE
Related constructs and concepts	Motivation, Commitment, Psychological contract
Case study context	NHS Learning and development Culture Employee Engagement and NHS
Critical Perspectives	Employee Engagement as Discourse New Public Management Organizations as sites of struggle

Table 4. Literature Review Terms, concepts and themes

Origins and definitions of and claims for the employee engagement construct

The term EE was coined by William Kahn in 1990 in a paper in the *Academy of Management Journal* entitled 'Conditions of personal engagement and disengagement at work'. Kahn took an ethnographic approach in his studies of summer camp counsellors and staff in an architecture firm. His specific concern was in exploring the experience of the individual at work; what it means for a person to be 'psychologically present' during 'work role performances', and how they can be 'disengaged'.

I define personal engagement as the harnessing of organization members' selves to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performances. I define personal disengagement as the uncoupling of selves from work roles; in disengagement they will withdraw and defend themselves physically, cognitively, or emotionally during role performances. (Kahn, 1990: 694)

Other writers explore the idea of engagement and consider how organizations might be able to enhance EE towards achievement of organizational goals. As well as drawing on Kahn, work has drawn on research into related concepts such as motivation, burnout, commitment, empowerment and organizational citizenship behaviour (OCB), which includes discretionary or 'extra-role' behaviour. Studies have sought to demonstrate that EE is measurable; that it can be correlated with performance; that it varies between individuals; and that employers can impact on people's level of engagement, the latter being of particular relevance to HRD interventions (Allen and Meyer, 1990; Macleod and Clarke, 2009).

In common with many such constructs, there is no one agreed definition of EE; during the course of a major review for the UK government, MacLeod and Clarke (2009) came across more than 50 definitions. Definitions of EE encompass attitudes, behaviours and outcomes; as in Kahn's work, elements of the experience of engagement can be emotional, cognitive and physical. Shuck and Wollard (2010) carried out a literature review to identify the seminal foundations of EE from the perspective of HRD. Their definition focuses on the individual employee and on the organizational interest: 'an individual employee's cognitive, emotional, and behavioural state directed towards desired organizational outcomes' (Shuck and Wollard, 2010: 103). Others mention motivation and 'willing contribution of effort' (often cited as a willingness to 'go the extra mile' for the employer), positive emotions such as job satisfaction and feelings of empowerment, feelings of connection towards colleagues

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and to the organization, with a resulting positive impact upon performance (CIPD, 2008; Gatenby et al., 2009).

There is often an emphasis on the role of the organization in fostering engagement and specifying the desired outcome of engagement, suggesting a two-way relationship between employer and employee (Robinson et al., 2004). Engaged employees are said to feel commitment to organizational values and to be motivated to contribute to the success of the organization, whilst experiencing a sense of wellbeing. Macleod and Clarke (2009) talk of a ‘virtuous circle’, where the preconditions trigger engagement and the results reinforce it. The UK professional body, the Chartered Institute of Personnel and Development (CIPD) defines employee engagement as:

a combination of commitment to the organization and its values plus a willingness to help out colleagues (organizational citizenship). It goes beyond job satisfaction and is not simply motivation. Engagement is something the employee has to offer: it cannot be ‘required’ as part of the employment contract. (CIPD, 2008:1)

‘ a positive attitude held by the employee towards the organization and its values. An engaged employee is aware of the business context, and works with colleagues to improve performance within the job to the benefit of the organization. The organization must work to develop and nurture engagement, which requires a two-way relationship between employees and employer’ (Robinson, et al., 2004).

‘We define engagement as ‘being positively present during the performance of work by willingly contributing intellectual effort, and experiencing both positive emotions and meaningful connections to others’ (Gatenby, et al., 2009: 3).

‘An engaged employee experiences a blend of job satisfaction, organizational commitment, job involvement and feelings of empowerment. It is a concept that is greater than the sum of its parts’ (IES)

‘A set of positive attitudes and behaviours enabling high job performance of a kind in tune with the organization’s mission’ (Storey et al., 2008).

‘A workplace approach designed to ensure that employees are committed to their organization’s goals and values, motivated to contribute to organizational success, and are able at the same time to enhance their own sense of well-being. Engaged organizations have strong and authentic values, with clear evidence of trust and fairness based on mutual respect, where two-way promises and commitments – between employers and staff – are understood and are fulfilled (MacLeod and Clarke, 2009: 8).

Table 5. Definitions of Employee Engagement.

Source MacLeod and Clarke (2009); Robinson, Hayday and Perryman (2004).

Although there are common elements to the definitions of EE (Brewster et al., 2007), they carry different emphases, underpinning assumptions and purposes and tend to be largely

from a normative perspective. Many are very broad, presenting overarching concepts and vision statements rather than being strictly definitions (Dicke, 2007).

EE has become big business with large and small consultancies offering to enhance engagement. Governments have commissioned major studies and put significant resources into the issue. For example, a UK government website launched in 2010 to help leaders and senior managers across the public, private and third sectors 'reap the benefits of EE' claims that: 'In an era of constrained resources, where nearly every organization is seeking "more for less", there are few industries that can afford to ignore EE' (Macleod, 2010 online). Others argue that to compete effectively, companies must enable employees to apply their full capabilities to their work.

Contemporary organizations need employees who are psychologically connected to their work; who are willing and able to invest themselves fully in their roles; who are proactive and committed to high performance standards. (Bakker et al., 2011a: 4–5)

Higher levels of EE have been associated with better financial performance in the private sector, better outcomes in the public sector and innovation. Engagement has been correlated with reduced sickness absence, reduced turnover, enhanced customer focus and advocacy for the organization (MacLeod and Clarke, 2009). Brewster et al. (2007) conducted an extensive literature search and face-to-face interviews, looking at what outcomes organizations were seeking from engagement. Findings included a desire to increase customer satisfaction and promote customer loyalty, improve customer service, facilitate change management, sustain growth and reduce turnover, to attract, retain and motivate staff.

Differences have been found in levels of engagement between types of work and workplaces, and differences in respect to levels of engagement. 4-Consulting (2007) found that the most engaged employees tend to be those in the youngest and oldest age groups, and that managers and professionals have greater levels of engagement than their colleagues in supporting roles. Robinson et al. (2007) also found that managers have higher levels of engagement than staff in operational, professional or support roles. Those in operational roles were found to have higher engagement levels than support staff. Perhaps surprisingly, professionals were found, overall, to have the lowest organizational engagement levels of all groups, in contrast to the findings by 4-Consulting (2007).

Attridge (2009) identified a general pattern of distribution of engagement amongst employees, which fell into three basic groups. The top 20 per cent are highly engaged: such employees 'work with passion and feel a profound connection to their company' (Attridge, 2009: 387). Sixty per cent are moderately engaged. However, there is concern over the 20 per cent of employees who were found to be actively disengaged. It is claimed that these employees are not just unhappy in their work, but they undermine more engaged co-workers. A survey by Towers Perrin found that 12% of UK public sector staff were highly engaged and 22% were disengaged.

Overall indicative figures suggest that levels of engagement in the UK are lower than they could be. Gallup suggests that in 2008 the cost of disengagement to the UK economy was between £59.4 billion and £64.7 billion (Robinson et al., 2007).

Despite the widespread popularity of EE, there are competing interpretations in how it is defined and perceived, and there is still limited academic research to back up many claims made as to its worth. How engagement develops, how it is measured, and whether there are different types of engagement are all subject to debate. Some sources refer in general terms to engagement and its 'presumed positive consequences' (Macey and Schneider, 2008: 3–4), whereas others identify different types of engagement, for example cognitive engagement, emotional engagement and behavioural engagement (Shuck and Wollard, 2010). Studies cover different sectors and use different methodologies, use a variety of definitions of engagement, focus on different elements of engagement, look at different performance outcomes, and at the contextual nature of engagement (Macleod and Clarke, 2009). Studies have been carried out by academics, consultancies and policymakers, each having potentially different interests and expectations. This clearly indicates caution when reviewing and comparing findings.

Practitioner models of engagement (Zigarmi et al., 2009) tend to focus on the practicalities such as how to use the construct, and on outcomes. Research methodologies have been accused of being based in some cases 'on anecdotal experience and good marketing' (Shuck, 2011: 17). Engagement as a 'folk' term has been used to refer to a psychological state, a 'performance constructed disposition', or a combination of the two (Macey and Schneider, 2008). As a psychological construct it has been used to refer to both role performance and an affective state, including mood states and more temporary emotional states. It is also referred

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to as a disposition or trait, or the tendency to experience events, circumstances and situations more positively (Macey and Schneider, 2008: 11). Macey and Schneider (2008) present a useful conceptual framework, which distinguishes between trait engagement, state engagement and behavioural engagement. They suggest that engagement as ‘state’ has received more attention, either implicitly or explicitly, than other perspectives.

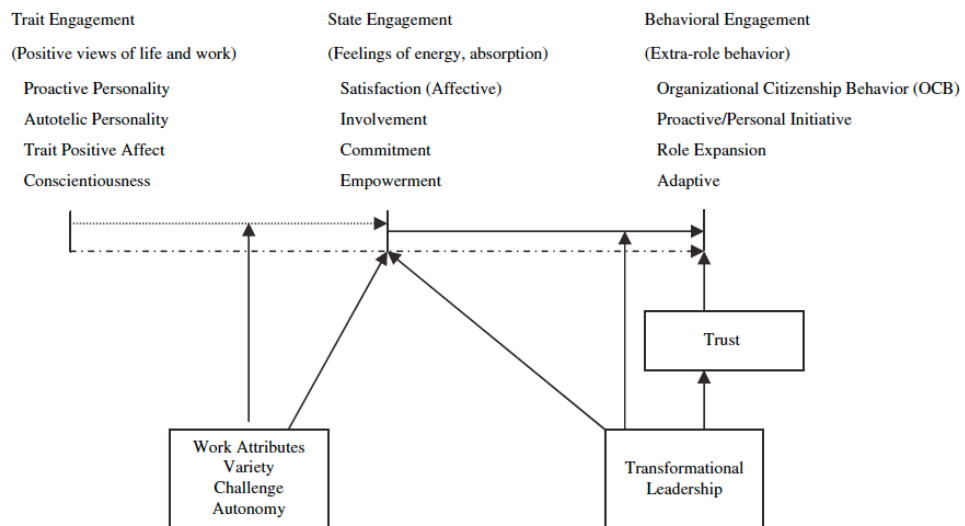


Figure 1. Framework for understanding the elements of employee engagement.

Figure 4. Framework for understanding the elements of employee engagement (Macey and Schneider, 2008).

In the psychological literature it is common to refer to ‘work engagement’ (WE), a more in-depth exploration of the individual experience than in some of the management literature, as might be expected. Three dimensions of the experience of WE have gained much attention. High levels of energy and mental resilience are referred to as *vigour*. A strong involvement in one’s work coupled with a sense of significance and pride is termed *dedication*.

Absorption describes the experience of full concentration and being engrossed in work (Fairlie, 2011: 509). WE seeks to capture that workers should experience their work:

as stimulating and energetic and something to which they really want to devote time and effort (the *vigour* component); as a significant and meaningful pursuit (*dedication*); and as engrossing and something on which they are fully concentrated (*absorption*). (Bakker et al., 2011a: 5)

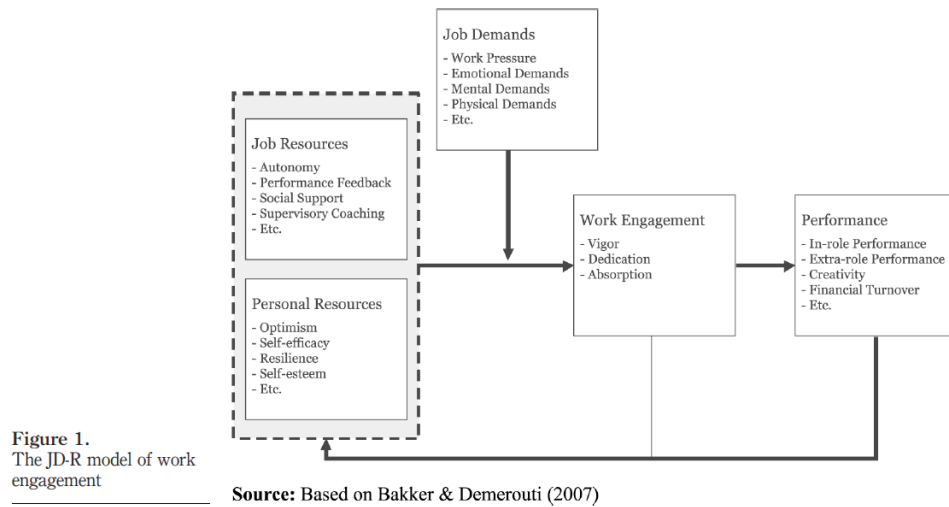


Figure 5. The JD-R model of work engagement (Bakker and Demerouti, 2008)

Practices to build an engaged workforce

Having introduced the concept of EE, this section looks at some of the common practices that organizations employ to attempt to increase engagement. As a starting point, engagement is typically measured by an employee attitude survey to assess how employees feel about issues in their work such as pay and benefits, communications, learning and development, line management and work–life balance (CIPD, 2008). There are a number of such surveys available. For example, one widely used measure of engagement is the Gallup Workplace Audit (Harter et al., 2002). This consists of 12 questions around the experience of work, including such things as: being clear around expectations, having resources to complete work requirements, support and recognition from managers, opportunities for development, and social relationships. The ratings from all 12 of these questions are then combined into an index – ‘being engaged’, ‘not engaged’, or ‘disengaged’.

The EE index developed by Robinson et al. (2004) also has 12 attitudinal statements. These are listed under the following categories: commitment to the organization and identification with its values; belief that the organization enables the individual to perform well; being a good organizational citizen, i.e. having a willingness to help others and be a good team player, to ‘go the extra mile’ and understand the wider context of the business. The indicator gives a score from one (highly disengaged) to five (highly engaged), with three as the neutral

midpoint (Robinson et al., 2007: 3). Towers Perrin (2008) developed a four-category scale with questions under the categories of: think, feel, act – extra effort, and act – stay.

The Utrecht Work Engagement Scale (UWES) (Schaufeli and Bakker, 2003) has 17 questions, and unusually is available freely online in over 20 languages (results contribute to ongoing research). It focuses on the individual's feelings and experience, including such statements as 'At my work, I feel bursting with energy', and 'I feel happy when I am working intensely', which provides a focus more on the psychological experience of the employee. It measures three different forms of behaviour (proficiency, adaptivity and proactivity) and three levels at which role behaviours can contribute to effectiveness (individual, team, organization), giving rise to a matrix of nine subdimensions of performance (Parker and Griffin, 2011: 65).

There is not space here for an in-depth analysis and comparison of engagement surveys, other than to note that they exhibit some similar features but also some possibly quite significant differences, and that some have been subject to more research than others. Latham (2007), discussing work motivation, suggests that attitude surveys are a useful way to assess the current thinking and the 'affect' of employees. Others are critical of such surveys when applied to EE, especially those developed out of practice rather than for research. Measures of engagement are accused of being 'composed of a potpourri of items representing one or more of the four different categories: job satisfaction, organizational commitment, psychological empowerment, and job involvement' (Macey and Schneider, 2008: 6–7). For example, the distinction between 'engagement' and 'satisfaction' is poorly conceptually clarified, and often there is simply a relabelling of measures used to assess job satisfaction (or climate or culture) as 'engagement'. Measures of 'conditions of engagement' are labelled as measures of engagement itself. There is neither any assessment of the *state* of engagement nor any indication of affect, energy or passion (Macey and Schneider, 2008). As Macey and Schneider note, this has conceptual limitations:

Although there may be room for satisfaction within the engagement construct, engagement connotes activation, where satisfaction connotes satiation ... 'Satisfaction' surveys might ask employees to describe their work conditions, and this may be relevant in assessing the conditions that *provide for* engagement (state and/or behavioural), they do not directly tap engagement. Such measures require an inferential leap to engagement rather than assessing engagement itself. (Macey and Schneider, 2008: 8)

Generic measures of engagement do not highlight differences between groups of people: cultural, generational or related to the nature of the job. Definitions may therefore need to be more relevant to the organizational context (Brewster et al., 2007). Surveys that are tailor made for the organization may be more useful, developed on the basis of interviews with samples of employees or focus groups (Latham, 2007). The efficacy and limitations of assessments that intend to measure EE needs to be further explored (Flesher, 2009). This echoes some concerns over the construct validity of organization commitment questionnaires (Ashman, 2007).

Measuring engagement is usually a precursor to interventions to promote engagement, followed by a 'package' of measures aimed both at the level of the individual employee and the wider organizational level (Attridge, 2009). Factors that have been found to impact on engagement include leadership and management style; open, two-way communication; issues such as pay and benefits; fair and equal treatment; employing the 'right' workforce; career development and training; working hours; and health and safety (4-Consulting, 2007: 1). Bakker et al. (2011a) suggest that 'job resources' such as autonomy, social support from colleagues and skill variety can play both an intrinsic and extrinsic motivational role for the individual worker: 'Results show that increases in social support, autonomy, opportunities to learn and to develop, and performance feedback were positive predictors of ... work engagement' (: 6). 'Drivers' of engagement are identified in 'clusters' – for example, the organization, management and leadership, and 'working life' (McBain, 2007). Robinson et al. (2007) distinguish between main drivers and subdrivers, arguing also that there is variability between and within organizations, and also individual differences.

The role of managers, and in particular the line manager, has emerged as a key factor in enabling and building engagement. Alimo-Metcalfe et al. (2008) carried out a three-year longitudinal study of 46 mental health teams working in the UK NHS. The study identified three dimensions to the leadership culture that supported engagement: engaging with others, visionary leadership and leadership capabilities. Employee engagement requires clear systems, processes and guidelines; a culture of engaging with staff, the antithesis of the 'blame culture'; and support for adaptability, experimentation, learning and innovation (Alimo-Metcalfe et al., 2008). The notion of 'engaging leadership' includes managers involving staff in developing a shared vision, being loyal to them, supporting them through coaching and mentoring, to help develop positive attitudes to work and a sense of wellbeing.

Others argue that ‘engaging managers’ should facilitate and empower rather than control or restrict their staff; they should listen, provide feedback, and offer support and recognition for effort (Macleod and Clarke, 2009).

HRD and employee engagement

Shuck and Wollard (2010) and Shuck (2011) produced some of the first papers to consider EE from a purely HRD perspective. Other HRD researchers have looked at antecedents to EE (Wollard and Shuck, 2011), employee perspectives on EE (Shuck, Rocco, and Albornoz, 2010), EE and Leadership (Shuck and Herd, 2012), linking theory and scholarship to practice (Shuck and Reio Jr., 2011). Despite the burgeoning popularity of EE, to date most of the research and writing has emanated from the HR or wider business literature. However, HRD processes and practices are inherent within most discussions on EE, and form a key part of practices claimed to facilitate engagement. EE writing makes a reference to the importance of training and development, learning processes, and specific interventions such as coaching and mentoring. There may be a general statement, along the lines that ‘training and development opportunities’ have been shown to contribute to engagement, or a more specific reference to a range of training and development interventions.

Robinson et al. (2007), for example, developed an EE diagnostic tool, which includes training, employee development and career development, arguing that these are key factors in helping employees feel valued and involved, and are seen to be major drivers of engagement. Questions in their engagement survey specifically focusing on training, employee development and career development included:

- I am encouraged to learn new skills.
- My line manager takes employees’ development seriously.
- I am able to take time off work for training.
- I have many opportunities for training.
- I am given adequate training to do my current job.
- My training needs are regularly discussed.
- I feel I have equal access to training and development opportunities.
- This organization actively supports my continuing professional development.

They note that: ‘In general, receiving training during the previous 12 months had a positive impact on engagement levels’ (Robinson et al., 2007: x). Engagement scores were higher for those who had received one or two days’ training, rising for those with three to five days, and six to ten days. Interestingly, those with over ten days’ training showed a drop in

engagement scores. They speculate that high levels of training might indicate for some respondents a performance problem that needs to be tackled.

They also ask about less formal development opportunities, such as secondments, coaching, multidisciplinary working and special projects. They found a direct relationship between respondents' views of development opportunities and their engagement levels: '40 per cent of those who thought that their development opportunities were good or excellent were highly engaged. Only 2 per cent of those who thought their development opportunities were good or excellent were disengaged' (Robinson et al., 2007: xi).

Having an appraisal or performance review within the past 12 months has been linked to engagement, as has possession of a personal development plan (PDP), having a good induction programme with training (Robinson et al., 2007), and career development opportunities and/or planning (Seijts and Crim, 2006). Kontakos sums this up:

An Employee Development Programme (EDP) designed for engagement aligns and monitors employees' job and career goals to the organizations' strategic goals. The development plan is customized for each employee, co-designed by the employee and fully supported by the line manager. Through the addition of accountability metrics, engaged employees recognize that their continuing value to the organization increasingly depends on achieving the goals of the plan. Subsequently, the organization secures the talent and skills necessary for operational excellence. (Kontakos, 2007: 76)

Relevant engagement practices range from supporting individual personal and professional development; support for staff to gain professional qualifications; skills development; management development programmes; induction programmes; work shadowing, job rotation and secondments; professional development portfolios and career planning; supporting communities of practice; formal training and on-the-job learning. An 'integrated HR offer' (Brewster et al., 2007) has familiar features associated with a strategic approach to HRD (SHRD) (Walton, 1999; McCracken and Wallace, 2000; Garavan, 2007).

Also of particular significance to HRD is the widely argued-for importance of both line managers and senior management support for EE. This indicates a further management and leadership development role for HRD in order to develop both team leadership and management skills in general, and the particular skills needed to become 'engaging managers'. The scope of these processes and interventions is summarised in Table 6 overleaf, drawn from the literature studied for this chapter.

Rationales for HRD interventions
Engagement is critical to managing change at work. Skills development and training is required as a more skilled workforce is able to adapt more rapidly to organizational technological change.
Evidence that individual skills are being underutilized at work.
Gallup suggests that in 2008 the cost of disengagement to the British economy was between £59.4 billion and £64.7 billion.
Restructuring in the manufacturing sector means the need to change the mindset of employees from that of a traditional manufacturer to one that is more flexible, dynamic and entrepreneurial.
Restructuring means need for a set of new skills.
Engagement strategies help to develop new skills, and motivation and commitment.
Engagement underlines the importance of HR engaging business strategy and goals, as well as ensuring that wider HR policies and practices which impact on engagement, such as training and development, are in place.
Employees psychological connection with their work has gained importance in the information/service economy of the 21st century. To compete effectively, companies must not only recruit the top talent, but must 'inspire and enable employees to apply their full capabilities to their work. Contemporary organizations need employees who are psychologically connected to their work; who are willing and able to invest themselves fully in their roles; who are proactive and committed to high performance standards' (Bakker et al 2011: 4-5).
Training and Development practices
'Partnership for learning' project supported by the organization, trade union and local college to improve literacy and numeracy skills, improve the motivation and confidence of staff and widen participation in learning.
Focus on empowering people and supporting individual personal development;
Coaching and mentoring programmes
Supporting staff in gaining professional qualifications
A programme around customer best care to all employees.
Complement a technical training programme with an engagement approach which highlighted the new set of skills the organization required to take it through change.
Greater learning and development opportunities, new management development programmes, employee recognition schemes, and flexible working practices.
A teaching and learning academy which support all staff to uphold the organization's ethos.
Full induction programme
People are given the opportunity to pursue with a personal development plan and talk through their career goals at least twice a year.
Learn new skills from a 'matched contribution' learning scheme
Online academies which offer training on a broad range of subjects.
Communication of the organization's career development principles and practices. Career mapping tools and workshops to help employees manage their own career direction. Example: Sub site on corporate intranet termed 'invest in yourself'. This included an outline of career development policies, career maps and self-assessment, and the catalogue of over 400 training courses available
Employees are encouraged to move around the company to vary their work and support their development.
Close business one day per week to carry out group training.
Train all employees in problem solving
Having opportunities to develop the job.
Having a PDP
Development opportunities such as secondments, coaching, multidisciplinary working and special projects
Formal training opportunities.
Professional communities and learning academies
Job rotation, internal transfer, and changing jobs stimulate learning and professional development

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Management and leadership development practices
Leadership which ensures a strong, transparent and explicit organizational culture
Commitment to improving the capabilities of all managers and educating them in their role as team leaders.
'Back to the floor' programmes giving senior leaders the opportunity to experience a customer facing role for a period, working with staff and discovering at first hand the issues they face in delivering to the department's customers.
Training and support for line managers; good basic management skills, rather than specific training on how to engage staff, have improved engagement across the company.
A manager's Charter which defines a new role for line managers as people who successfully recruit, lead, enable, appraise, develop, evaluate and recruit people in their teams. Leadership programmes and skills training to support those in line manager roles.
Leadership development programmes designed to move away from a command and control system to one where people felt able to show leadership wherever they were in the organization. Core to this cultural change was a training programme to managers showing them how to take a coaching approach to leadership of their teams.
A pool of volunteer management coaches is used to coach others across the company.
All managers are supported to the 'great managers' programme which includes a mix of training online tools and communications
A range of branded leadership development materials and activities, including a practical and 'great management' toolkit was produced.
A corporate university '.... Academy'
Senior managers of some SMEs undertaking development programmes offered by Universities
Training for managers in 'people skills'
Senior executives set the tone of engagement in an organization
Managers conduct performance reviews and help employees with performance development and career plans.
Accredited training programmes for managers
SHRD practices
A clear statement of the organization's aims and values and a well communicated strategy
Exercise to communicate and discuss organizational vision and values at workshops with all employees, explaining what they mean in practice to each individual
Introduction of performance related appraisal scheme, performance management systems, integrated with organizational strategy
Start the year with a major conference for all managers
An annual intensive two-week programme of engagement and communication.
Engagement champions armed with the tools to help drive engagement at a local level and support line managers improving their people management capability.
Improved communication on organizational objectives,
A network of 'culture' leaders selected from each team who were trained to run group workshops for staff to come up with three or four actions of improvements around customer service, partnerships or team working.
Hundreds of staff gathered at a one-day conference to rethink the way the organization approached services.
The development of a workplace learning strategy in participation with unions
Overall good people management and development policies, aligned to those of the wider business.
HR as a function has the responsibility to ensure that line managers are equipped to do the job of managing people effectively.
Regular engagement surveys.
A corporate culture, which fosters employee growth and development
HRD practitioners as engagement champions.

Table 6. HRD interventions to support employee engagement

Fairlie (2011) suggests that one way that HRD can address engagement is to promote 'human development'. He argues that meaningful work can be shown to link to engagement, and development is a core aspect of meaningful work. In a study involving 574 questionnaire recipients, he found that meaningful work characteristics were the strongest predictor of engagement: 'Given the development theme that is inherent in meaningful work (i.e. self-transcendence), the results would suggest a prominent role for HRD professionals in addressing these issues within organizations' (Fairlie 2011: 517). He suggests that meaningful work should be audited on employee surveys, and makes a number of other suggestions as to how HRD professionals could communicate opportunities for meaningful work and enable the development of more opportunities.

Motivation, commitment and employee engagement

Whilst there is not space to go into detail in this chapter, as employee motivation and commitment are important contributors to the concept of EE, some discussion is appropriate to inform our understanding. This section explores the link between EE and these earlier constructs. Meyer et al. (2004) note that the commitment and motivation literatures in organization psychology have evolved independently. Theories of work motivation have evolved out of general theories of motivation, whereas commitment study has its origins in sociology. Both concepts have been difficult to define. They argue that commitment and motivation, although related concepts, are distinguishable, and they suggest that commitment is one component of motivation. Latham (2007) argues that there is no integrative overarching conceptual framework for motivation.

Organizational commitment describes the employee's involvement and identification with their organization, and there are many similarities between EE and commitment. The concept of 'perceived organizational support' (POS) refers to how the employee views the degree that the organization is committed to them (Ferrer, 2005). Robinson (2003) distinguishes between five types of organizational commitment:

- Affiliative – compatible with organizations interests and values
- Associative – perception of belonging
- Moral – sense of mutual obligation
- Affective – job satisfaction
- Structural – fair economic exchange. (Robinson, 2003: 12)

Meyer et al. (2004) develop an integrative model in which commitment is part of a more general motivational process, which also treats motivation as a multidimensional construct, and distinguishes between nondiscretionary and discretionary behaviour. Basic mechanisms are presumed to be involved in the development of commitment. Other factors (including human resource management practices and policies) serve as more 'distal causes' for motivation. This underlines the importance of not viewing motivation (and EE) as something that can be simply 'switched on' by appropriate HR/D policies and practices. Commitment is influenced by many factors, including 'environmental factors' such as 'leadership, the social milieu, and the work itself' (Meyer et al., 2004: 1002).

Meyer et al. (2004) also distinguish between three different elements to commitment; affective, normative and continuance: 'affective attachment to the organization, obligation to remain, and perceived cost of leaving' (2004: 993). Research shows that affective commitment has the strongest positive correlation with job performance, OCB and attendance, followed by normative commitment. Continuance commitment tends to be unrelated, or even negatively related, to these factors (Meyer et al., 2004). Since EE surveys incorporate questions related to these aspects of commitment, for example asking if employees intend to stay working in their current organization, it can be seen that they draw selectively on research into organizational commitment. However, there is a danger that such surveys and their interpretations oversimplify complex human processes, and that theories of EE lack robust research of the kind that has been done into commitment and motivation.

Focusing on the issue of commitment from an HRD perspective, McCabe and Garavan (2008) suggest that organizational commitment is related to four factors: commitment to the organization, to top management, to immediate superiors and to workgroups (2008: 533–534). In their study of nurses they noted a range of factors influencing commitment, including shared values; leadership, teamwork and support; training, development and career progression; valuing and staff recognition; professional, organizational commitment and involvement. These are very similar to some of the suggestions for EE.

Factors which are suggested to impact upon EE also have an impact on factors such as motivation to engage in training and transfer of learning to the workplace. McGuire (2011) argues that the motivation of trainees is a factor in the success of training and the transfer of training. Supervisor support will affect trainee motivation.

Chalofsky and Krishna's (2009) reference to 'meaningful work' again echoes much in the EE literature. They identify three themes: sense of self, the work itself and sense of balance. They argue that 'the primary drivers of commitment are identification with the organization's goals and values, congruence between individual and organizational goals, and internalization of the organizational value and mission' (Chalofsky and Krishna, 2009: 198).

All the above suggests that we should not ignore research on motivation and commitment in favour of the 'newer' construct of EE. And commitment and motivation are themselves multidimensional constructs: so what complexities are added when one suggests that they are intrinsic components of EE, itself a multidimensional construct? Added to this one needs to take account of the different emphases of research in disciplines such as psychology and sociology.

Parker and Griffin argue also for a need to relate empowerment literature to engagement. 'Psychological empowerment refers to the motivational state of experiencing meaning, impact, competence (or self-efficacy), and self-determination' (Parker and Griffin 2010: 62).

Psychological wellbeing has been shown to be correlated with performance. Robertson and Cooper (2010) argue that the current focus of EE concentrates on the organizational benefits of employee commitment, attachment and citizenship, and not enough on employee psychological wellbeing. They suggest that this reflects a focus on 'Narrow Engagement', and argue for an integrated concept of 'Full Engagement', which pays equal attention to the wellbeing of individuals. To focus only on commitment and citizenship may risk employee's psychological health (Robertson and Cooper, 2010). This has some parallels with the idea of 'hard' and 'soft' HRM (Storey, 1989).

EE also has links to studies into the psychological contract, which refers to the perceptions of employee and employer of their mutual obligations to one another (Guest and Conway, 2002). MacLeod and Clarke's (2009) definition of engagement emphasizes the role of the organization, in a similar way to that of the psychological contract literature: 'Engaged organizations have strong and authentic values, with clear evidence of trust and fairness based on mutual respect, where two-way promises and commitments – between employers

and staff – are understood and are fulfilled (MacLeod and Clarke 2009: 8). There is a danger that the term *employee* engagement emphasizes the need for employees to be engaged without recognizing the mutual obligation of the *employer* organization. Many organizations now seek to spell out the reciprocal nature of commitment. Walton (1999) gives examples of ‘commitment’ and ‘value’ statements in which organizations attempt to articulate their internal and external values. Clearly to be credible these need to be backed up by appropriate policies, procedures and actions.

The team as a locus of engagement

The focus of much discussion on EE tends to be on the individual’s engagement with the organization. However, employees may be engaged with aspects of their work, and not necessarily with the organization as a whole. Research into the ‘locus of engagement’ has found that employees identify with their team and business unit more strongly than with the wider organization (CIPD, 2011: 3). This can be explained by the fact that ‘people tend to be engaged with elements of their work environment which they encounter frequently, namely, their job and their immediate colleagues, including their line manager’ (CIPD, 2011: 19). However, there has been limited research to date into this aspect of EE. Since working in groups and teams is a significant factor in organizations, a useful focus is to locate the level of analysis of EE at the group level. This section examines some of the work in this area and draws out some implications for HRD.

A work team can be described as a group of individuals who work interdependently to solve problems or carry out work (Kirkman and Rosen, 1999: 58). There is much emphasis in engagement literature on the importance of the ‘engaging manager’, but might there also be a role for the ‘engaging co-worker’? A range of questions emerge: can teams/work groups contribute to individual EE? Can team management and development practices contribute to the engagement of individuals? Can engaged team members contribute to engagement of others in the team? Can a ‘team’ be ‘engaged’? Can we talk about ‘engaging’ team leadership and management?

Although there is little in the EE research to date to address these questions, we can draw on the extensive research on motivation and commitment in work groups and teams. Commitment theory recognizes that ‘commitment can be directed towards various targets, or

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foci, of relevance to workplace behaviour, including the organization, occupation, supervisor, team, program, customer, and union' (Meyer et al., 2004: 993–994). The team is an important source of organizational support, one that influences commitment (Bishop et al., 2000), and therefore engagement.

Meyer et al. (2004) introduce the term 'commitment to social foci' as distinct from 'commitment to the goal'. This commitment may be affective, in which case the individual employee will tend to share the values of the particular target of commitment, and is likely to 'experience self-set and assigned goals as autonomously regulated (integrated or identified regulation) and as ideals to be achieved' (Meyer et al., 2004: 1001). This suggests that the work group or team can act as a contributor to engagement.

A strong normative commitment, in contrast to affective commitment, means that individuals are likely to perceive goal acceptance as more of an externally regulated obligation. Normative commitment develops through cultural and organizational socialization and contributes to persistence in motivation (Meyer et al., 2004). This can also happen at the level of the team.

'Perceived team support' (PTS) has been related to job performance (Bishop et al., 2000: 1128). Support from the organization and support from the team may impact on employee commitment in different ways. Level of turnover, for example, seems to be more correlated with perceived support from the organization. Job performance, however, seems to be more influenced by a supportive team environment, one that acknowledges and values individual members' contributions (Bishop et al., 2000). This suggests that the team can serve as a 'driver' of engagement. Commitment to organizational goals is mediated through commitment to a supervisor or team. Thus it is not only the action of managers that can support engagement, but also the role of the team.

Commitment may also be to a profession or to customers and client, with the same effect (Meyer et al., 2004). Research has explored the organizational commitment of professionals versus their commitment to their profession. Wallace (1995) in a study of lawyers working in large non-professional organizations found that organizational commitment was subject to a number of factors. These lawyers tended to create a subculture within the company, and shared a common culture of commitment to professional ideals and values. Commitment to

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the organization evolved through an adaptation of their professional ideology to incorporate the ideals and goals of the employing organization. Thus subgroups can contribute to aspects of engagement.

Exploring the issue of workplace motivation from an HRD perspective, Chalofsky and Krishna (2009) advocate a holistic approach that takes into account contextual and organizational factors. They argue that 'although motivation is an individual and personal process, it is also significantly influenced and shaped by the contextual and organizational factors' (Chalofsky and Krishna (2009:191). One of these is clearly the group/team. Again, as motivation is an aspect of engagement, this research is of interest.

HRD research has looked into learning in groups from the perspective of communities of practice. Based on social learning theory, the focus is on how people construct meaning when they interact with one another in working life, and with technologies and tasks, and how learning emerges from social interactions. Knowledge is public not private, 'in the sense that people use publicly accessible symbolic tools (myths, concepts, stories, narratives, rituals, traditions, procedures) for communicating, collaborating and interacting with others' (Molbjerg Jorgensen, 2011: 110).

A similar perspective is cited by Hatch and Yanow (2003). Phenomenology argues that the process by which a problem comes to be framed is also a process of creating intersubjective understanding in a community 'in which members come to share a set of practices, knowledge about those practices, about one another, and about how to address new situation....interpretation, then, rests on a community of meaning' (Hatch and Yanow 2003: 68). Tacit knowledge is shared among members of an interpretive community.

There is evidence that factors associated with EE do focus at the level of work groups/teams. 'Job resources', including social support from colleagues and supervisors, have been positively associated with WE (Bakker and Demerouti, 2008). It has been argued that engaged workers perform better, and that the crossover of engagement among members of the same work team creates a positive team climate, and increases performance in others. Positive emotions experienced by engaged workers transfer engagement to others (Bakker and Demerouti, 2008; Bakker et al., 2006).

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The study of motivation on team effectiveness has looked at the way that team members motivate or demotivate one another (Latham, 2007). Processes of 'social identification' occur and people tend to identify with a group that distinguishes them from others. This occurs more with smaller rather than larger groups, as they are more inclusive: 'In larger groups, one's conception of self in relation to others is less informative since this is an identity that "everyone" shares' (Latham, 2007: 257). One could surmise an important role for the team as a locus of engagement.

As noted earlier, engagement interventions typically start with some sort of organization commitment survey, which assesses the level of engagement with 'the organization'. However, in the light of Latham's findings, it might be possible for an individual to demonstrate a lack of engagement with organization-level priorities, but to demonstrate engagement at the level of the team, and of the task. This suggests including more of a survey of 'team climate' or 'team commitment', contextualized at work group or team level. Rather than a generalized survey, this should be tied to the function and tasks of the teams being studied. It could focus on aspects such as quality or customer satisfaction, and be linked to methods such as the balanced scorecard approaches (Mathieu et al., 2008: 418). Engagement interventions might also usefully take place at the level of the team, in combination with the organizational or individual level. Teamwork competencies themselves can also be improved through training interventions (Mathieu et al., 2008), and this might in turn impact upon engagement.

As we have seen, a particular focus in EE is on the importance of taking an 'engaging' approach to management and leadership. Team leadership may be a useful focus for the study of EE, building on what is almost a century of previous research and theory into leadership research (Parker and Griffin, 2011). For example, transformational leadership behaviours have been positively related to perceived team effectiveness. Shared leadership suggests that leadership functions can be distributed across multiple team members rather than arising from a single formal leader (Mathieu et al., 2008: 450). Both these aspects have resonance with the argument around 'engaging managers'. Kirkman and Rosen (1999) looked at leader behaviours and team responsibility in 111 teams from four organizations. They found that external leaders' actions enhanced empowerment experiences. Empowered teams exhibited higher levels of productivity, customer service, job satisfaction, organizational and team commitment. Coaching has also been found to positively influence

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self-management, team-member relationship quality, member satisfaction, team empowerment and psychological safety (Mathieu et al., 2008).

Srivastava, Bartol and Locke (2006) studied 'empowering leadership' in management teams and its effects on knowledge sharing, efficacy and performance. Although their study focuses on knowledge sharing, they make a number of useful observations relevant to this study. They defined empowering leadership as 'behaviours whereby power is shared with subordinates and that raise their level of intrinsic motivation' (Srivastava, Bartol and Locke, 2006: 1240). Examples of empowering leader behaviour include: leading by example, participative decision-making, coaching, informing and showing concern. Clearly the notion of 'engaging leadership' has many similarities.

Kirkman and Rosen's (1999) work on team empowerment has resonance for EE. They define empowerment as 'increased task motivation resulting from an individual's positive orientation to his or her work role' (Kirkman and Rosen, 1999: 58). They see team empowerment as having four dimensions:

Potency – the collective belief of a team that it can be effective.

Meaningfulness – team's experiencing its tasks as important, valuable and worthwhile.

Autonomy – the degree to which team members experience substantial freedom, independence and discretion in their work.

Impact – when a team produces work that is significant and important for an organization (Kirkman and Rosen, 1999: 59).

This notion of empowerment goes beyond the idea of 'engaging leaders' to suggest a significant role for the team itself in facilitating engagement.

As teams become established and legitimate, they participate in networks and gain access to strategic organizational information, and have a greater sense of their impact on overall organization performance (Kirkman and Rosen, 1999). Team empowerment can be impacted from four areas – external leader behaviour, production/service responsibilities, team-based human resource policies and social structure (Kirkman and Rosen, 1999). 'Empowering leaders' are seen to exhibit similar behaviour to the 'engaging leaders' of EE. This includes 'delegation of responsibility to the team, soliciting team input into decision-making, seeking to enhance the sense of personal control of individual team members, encouraging team

goal-setting and self-evaluation, and setting high team expectations' (Kirkman and Rosen, 1999: 60). However, potential problems with multiple loci of engagement may also need to be considered. For example, members of teams may experience greater loyalty to the team than to the organization, which may hinder overall performance (CIPD, 2011).

Employee engagement – an emerging construct

It seems that EE is here to stay. It is a concept that has evolved in popularity in practice, and for which there is an increasing amount of research being undertaken. Engagement has been heavily marketed by consultancy companies, appears to have a resonance with practitioners and policymakers, and taps into ideas about the meaning of work (Parker and Griffin, 2011). There are questions around whether it really is adding something new, given that definitions and meanings of engagement in the practitioner literature often overlap with other earlier constructs. It is, however, presented as a more distinct construct in the academic literature. Following an extensive critique, Macey and Schneider (2008) conclude that the concept of engagement does have distinctive characteristics, as an integrated set of constructs, interrelated and with relationships to a common outcome. Saks (2006) concurs that it is distinguishable from related constructs such as organizational commitment, OCB and job involvement.

However, it is important to recognize the contested nature of much of what passes for research and practice in EE. If it is to be a useful construct then it needs to be regarded as one that is complex and multi-faceted. We need to draw on the research being done in the various relevant domains within management studies and work psychology. In the urge to discover something new, we should not dismiss the huge body of research and theory in contributory areas such as commitment and motivation.

A special issue of the *European Journal of Work and Organizational Psychology*, online in August 2010, was dedicated to a review of the concept of work engagement (WE). One overall conclusion was that there is sufficient theory demonstrating that WE is a motivational construct, but no overall agreement on how it is conceptualized, echoing discussion on EE. WE is variously defined as organizational commitment, especially affective commitment, as emotional attachment to the organization and desire to stay in the organization, and with respect to extra-role behaviour (discretionary behaviour) (Bakker et

al., 2011a). Two core dimensions of WE seemed to attract most agreement – energy and involvement/identification, which are both included in the Utrecht Work Engagement Scale (UWES).

There is also debate around whether EE is best conceptualized as a broad, generalizable construct (organizational climate) or a more specifically focused construct (service climate), climate for innovation (Bakker et al., 2011b). These different conceptualizations might suggest different levels and foci for engagement interventions. Another question is whether engagement is a stable state, or if there are fluctuations in engagement across the working day. Many studies appear to assume that engagement is expected to be relatively constant, given the presence of specific job and organizational factors. But this simplifies the possibility of engagement as a more temporal ebb and flow (Macey and Schneider, 2008: 11).

How engagement develops is another aspect of interest. Shuck and Wollard (2010) propose that cognitive engagement occurs before emotional and behavioural engagement. They suggest that cognitive engagement cannot be measured, as it is not yet behaviourally manifested. It is a catalyst to the next two levels. A more sophisticated understanding of engagement suggests that prescriptions for organizational efforts to promote engagement may need to be revised.

The costs of driving up EE have received limited consideration, in contrast to attempts to quantify the benefits. For example, over-engagement may have potential unintended consequences. If a worker gets overly involved in work activities, they may experience work/ family conflict, and other negative consequences (Brewster et al., 2007). Possible dangers of over-engagement could also include becoming too internally focused and over reliant on current organizational arrangements, leading to difficulties in coping with major change and contributing to stresses within teams (4-Consulting, 2007).

In Kahn's (1990) research, three psychological conditions necessary for individual engagement emerge: meaningfulness, safety and availability, and he explores each of these aspects further. For example, he suggests that psychological meaningfulness is influenced by three factors: task characteristics, role characteristics and work interactions. Kahn also notes that work behaviours include both rational and unconscious elements, which are influenced

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by individual, social and contextual sources, including interpersonal, group, inter-group and organizational factors (Kahn, 1990). The implications here are that engagement is not simply something that occurs uniformly under specific conditions, but is more personal and subject to a potentially wide range of contextual factors.

Engagement has been conceptualized as implying ‘discretionary effort’, defined as extra time, brainpower and energy; something special, extra, or at least atypical. However, ‘effort’ requires clear definition. Equally, if we define engagement solely in terms of extra effort, this suggests ‘just doing more of what is usual. It might equally involve doing something *different* and not just something *more*’ (Macey and Schneider, 2008: 40).

Having extensively reviewed EE, we now turn to other themes relevant to this study.

Table 7. Psychological condition of personal and engagement and disengagement at work (Kahn, 1990).

TABLE 1
Dimensions of Psychological Conditions

Dimensions	Meaningfulness	Safety	Availability
Definition	Sense of return on investments of self in role performances.	Sense of being able to show and employ self without fear of negative consequences to self-image, status, or career.	Sense of possessing the physical, emotional, and psychological resources necessary for investing self in role performances.
Experiential components	Feel worthwhile, valued, valuable; feel able to give to and receive from work and others in course of work.	Feel situations are trustworthy, secure, predictable, and clear in terms of behavioral consequences.	Feel capable of driving physical, intellectual, and emotional energies into role performance.
Types of influence	Work elements that create incentives or disincentives for investments of self.	Elements of social systems that create situations that are more or less predictable, consistent, and nonthreatening.	Individual distractions that are more or less preoccupying in role performance situations.
Influences	<p>Tasks: Jobs involving more or less challenge, variety, creativity, autonomy, and clear delineation of procedures and goals.</p> <p>Roles: Formal positions that offer more or less attractive identities, through fit with a preferred self-image, and status and influence.</p> <p>Work interactions: Interpersonal interactions with more or less promotion of dignity, self-appreciation, sense of value, and the inclusion of personal as well as professional elements.</p>	<p>Interpersonal relationships: Ongoing relationships that offer more or less support, trust, openness, flexibility, and lack of threat.</p> <p>Group and intergroup dynamics: Informal, often unconscious roles that leave more or less room to safely express various parts of self; shaped by dynamics within and between groups in organizations.</p> <p>Management style and process: Leader behaviors that show more or less support, resilience, consistency, trust, and competence.</p> <p>Organizational norms: Shared system expectations about member behaviors and emotions that leave more or less room for investments of self during role performances.</p>	<p>Physical energies: Existing levels of physical resources available for investment into role performances.</p> <p>Emotional energies: Existing levels of emotional resources available for investment into role performances.</p> <p>Insecurity: Levels of confidence in own abilities and status, self-consciousness, and ambivalence about fit with social systems that leave more or less room for investments of self in role performances.</p> <p>Outside life: Issues in people's outside lives that leave them more or less available for investments of self during role performances.</p>

Learning and change in the NHS

The focus on change and adaptability is key feature of management literature over the last 30 years, and represented in much HRD literature e.g. Harrison and Kessels (2004). Public sector organizations face twin pressures of reducing spending and providing more customer-focused services (CIPD/PPMA 2012). In the NHS, structural and managerial changes, policy developments, the drive for modernization and focus on performance, and labour shortages, provide a changing NHS context. The introduction of the policy of clinical governance emphasizes multidisciplinary responsibility in clinical areas, and a focus on evidence-based practice (Sheaff and Pilgrim, 2006; Sambrook, 2001; Davies and Nutley, 2009; 2000).

Referring to ‘The new NHS’ (Davies and Nutley, 2000: 999) (although, viewed over a decade later, perhaps not so new), the modern health care context is characterized by an environment of change and uncertainty, giving rise to a need for flexibility and innovation. Sambrook also notes an environment of ‘rapid, discontinuous change, accompanied by new internal structures, such as strategic business units and service level agreements’ (2001: 172). ‘Modernization’ has seen a drive for improved performance, and the focus has been on the management of organizational culture and improving learning, and close external monitoring. Policy developments emphasize short-term financial targets and contracts, which have resulted in corresponding changed psychological contracts with staff (Davies and Nutley, 2000). Sheaff and Pilgrim (2006) argue that policy shifts have created contradictory organizational effects, increasing bureaucratic complexity, creating systems of upward accountability, and weakening of professional authority, making the NHS now both more bureaucratized and more marketised, ‘it is neither fish nor fowl’ (2006: 9).

Looking at the Irish context, McCabe and Garavan (2008) also argue that the developments in the organization of health care delivery and the economic rationales have resulted in significant pressures on nursing staff, leading to conflicting priorities and contradictions in what services are aiming to achieve. They comment on changing philosophies and discourses surrounding the delivery of health care.

Workforce development in the NHS is claimed to be of increasing importance, and personal development of individual staff is now encouraged to make the NHS an attractive and reliable employer (Sheaff and Pilgrim; 2006). The support and promotion of learning

through continuing professional development (CPD) is a key factor in many recent initiatives in the health sector, promoted by government, and professional bodies, setting out a vision of lifelong learning in the NHS (Murphy et al, 2006). Work on the specific health care context has been carried out by Davies and Nutley (2000), which suggest that although continuing professional development has long been part of the NHS, evidence suggests that learning needs to take a more central role, in order to improve the capacity to innovate (Davies & Nutley, 2009).

Employee engagement and the NHS

There are a range of studies around engagement and the related concepts of commitment and the psychological contract in the NHS. In the UK, the Institute for Employment Studies (IES) published a first report on EE in 2004, entitled ‘Drivers of EE’ based on research in over 40 companies in the private and public sectors. They then tested the findings in the UK NHS.

Murphy et al (2006) employ the concept of the psychological contract to explore the issue of CPD for nurses. They examine inhibitors to CPD, noting that even when CPD programmes are available a significant proportion of nurses do not participate. Lack of study leave, balancing study with domestic responsibilities and work, rigid course requirements, lack of financial support, cost of education, and a lack of support from managers are all cited as inhibitors to undertaking CPD (Murphy et al, 2006).

McCabe and Garavan (2008) highlight issues which support motivation, such as ongoing professional training and development and support from management. ‘The findings indicated that strong and supportive leadership, at ward and strategic organizational level, positively influence the commitment of nursing staff’ (McCabe and Garavan, 2008: 559).

Alimo-Metcalfe et al (2008) studied health service managers, and argue that attitudes to work, particularly job satisfaction, are good predictors of organizational performance, measured in terms of productivity and profitability. Boaden et al (2008) conducted a study for the UK Department of Health, on ‘*Improving health through human resource management*’, which looked at how HRM can influence performance in NHS organizations, focusing particularly on issues of ‘engagement and alignment’. In this study, issues

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associated with 'training' and 'career development' were encompassed within a model of strategic HRM.

A recent report by CIPD and PPMA (2012) on *Leading culture change-employee engagement and public service transformation* argues that employers need to build a new psychological contract with staff. This should be underpinned by 'greater flexibility for individuals, skills and employability development opportunities, as well as good-quality people management and leadership to compensate for lower levels of reward and job security'. They argue that 'employee voice is key to service transformation'.

Truss, Currie, Robinson and Alfes are currently engaged in a research project for the UK National Institute for Health Research entitled *Enhancing and Embedding Staff Engagement in the NHS: Putting Theory into Practice*. They expect to report in September 2014.

NHS culture and learning

A key feature of change in the NHS is the espoused aim to achieve transformation in organizational culture. Culture can be interpreted as a total way of life of people, including their interpersonal relations as well as their attitudes, and as being composed of values, beliefs, norms, rationalizations, symbols and ideologies. The organization is seen as a 'culture producing phenomenon' or milieu with internal systems (rules, structure, norms, rites, myths, heroes and stories (Singh and Dixon, 2002). One way of conceiving of organizational cultures, is a reflection of a common way of making sense of the organization, including shared beliefs, attitudes, values, and norms of behaviour (Davies et al., 2009). Davies et al. (2009) map out the trend in cultural reform in the NHS, from the Griffiths reforms of the 1980s to the present. They suggest that reforms have attempted to introduce a management culture, overlaid onto a public service orientation, followed by internal market reforms. Attempts at cultural transformation may have succeeded only at a superficial level. 'Whereas the more visible artifactual elements of culture may be readily manipulated, deep-seated beliefs and values may prove more resistant to external influence' (Davies et al., 2009: 112). They suggest that caution must be exercised over the assumption of a simple causal link between culture and performance, which has not been sufficiently demonstrated.

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As Bolman and Deal (2008) note, organizations are complex, surprising, deceptive, and ambiguous.

Large organizations in particular include a bewildering array of people, departments, technologies, and goals. Moreover, organizations are open systems dealing with a changing, challenging, and erratic environment. (Bolman and Deal, 2008: 3)

Complex organizations have many sub-cultures, depending on a range of factors such as geography, sector, values and mission (Bowles et al., 2012). In the NHS there may be different cultures in relation to the varied healthcare professionals who have their own ethical standards and codes with which they need to comply. 'Nevertheless there will be an over-arching culture which is predominantly created and shaped by the Chief Executive and the senior leadership team' (Bowles et al 2012: 11). Where the behaviours and leadership styles are at odds with the avowed values of the organization, this can 'cause a cultural disconnect, with layers of disaffection, poor engagement patterns and inappropriate behaviour' (Bowles et al 2012: 11).

In the UK the NHS document of 2001, 'Working together, learning together' sets out a vision of lifelong learning in the NHS (Murphy et al, 2006). The notion of culture change accompanied by organizational learning leads into the idea of the learning organization (Waterman et al, 1994). The learning organization 'facilitates the learning of all its members and continuously transforms itself' (Pedler, Boydell and Burgoyne, (1988) in Dale, 1994). Davies and Nutley (2000) suggest that although continuing professional development has long been part of the NHS, evidence suggests that learning needs to take a more central role.

Rather than implementing fixed responses to change, learning organizations seek to develop structures and human resources that are flexible, adaptable, and responsive. Secondly, organizations need to learn in order to improve their capacity to innovate and hence to compete. (Davies & Nutley, 2000: 999)

Sheaff and Pilgrim (2006) in a seminal paper on the learning organization in the NHS, echoing earlier work by Edmonstone (1990), explore the development of a learning organization focus in the NHS from 1998-2006, asking 'can the current NHS nurture learning organizations'? They look at defining features of a learning organization (LO) from the literature, and draw out key themes, which they then examine in the context of the NHS. They highlight some aspects which support a learning organization. These are:

1. maximizing individual competency

2. open systems thinking
3. team learning
4. updating mental models
5. cohesive vision (Sheaff & Pilgrim, 2006).

They suggest that the notion of a learning culture encompasses issues such as communities of learners; learning leadership dispersed throughout the organization; people being confident to have an open dialogue about multiple perspectives; ongoing collective transformation and self-government (Sheaff & Pilgrim, 2006).

They suggest that the quasi market structures and accompanying bureaucratization that increasingly characterize the NHS are unlikely to successfully encourage a learning organization approach. Systems of accountability, new models of care, clinical governance, and evidence based medicine, combined with increasingly centralized and authoritarian leadership ('performance management') and bureaucratization of clinical governance and research governance within the constituent organizations of the NHS, have contradictory impacts (Sheaff & Pilgrim, 2006). They suggest that the capacity of NHS organizations to follow 'learning organization' norms remains constrained by two powerful interests- policymakers and clinicians; narrow, technical learning is encouraged.

Other commentators have criticised the learning organization as a technical /rationalist concept, more concerned with socialisation of workers into flexible ways of working rather than empowerment; workplaces are environments which constrain the learning process, rather than enabling individuals to become increasingly reflective, autonomous actors (Lankshear, 1997; Collins, 1995; Welton, 1995). Coopey (1995) argues that desire for open and collaborative learning requires changes in the framework and institutions of governance of organizations, and the political processes constrained by them.

Sambrook (2006), examining discourses of organizational learning and HRD in the NHS, emphasizes the multiple stakeholders who talk of HRD in varying ways, 'giving rise to multiple discourses of HRD' (2006: 49.) The aim of her study was to highlight factors influencing the commitment of nurses, and it particularly focuses on the role of training, development and career issues. The paper explores the tensions associated with management development in the NHS, between professional and managerial development, between

central and local HR activities, between competition and corporation, between a focus on performance and the need to learn (Sambrook 2006: 26).

Critical perspectives : Discourses of Employee Engagement and New Public Management in the NHS.

Alvesson and Willmott (2012) argue that knowledges of management can be either conventional or critical. Conventional management tends to have a 'technical' concern with finding solutions to problems that have been pre-defined by managers. They define management as 'a set of techniques and disciplines that promises to address problems that are defined as soluble by the technical solutions it provides' (Alvesson and Willmott, 2012: 3). A critical approach to management study views management as a social construction, not simply as a neutral, technical activity. 'Its content, both theoretical and practical is embedded in the historical and cultural relations of power and domination' (Alvesson and Willmott, 2012: 41). Critical management studies (CMS) provides a range of alternative ways to view management. Features of critical management and organizational research can encompass (Valentin, 2006):

- a focus on historical/social/political construction of organizational practices and arrangements;
- a concern to uncover processes of domination and subjugation in organizational life, and issues of power/knowledge;
- a focus on 'Problematizing' rather than 'problem-solving', including Problematizing how 'reality' is represented, and offering alternative readings;
- the centrality of discourse, how particular perspectives on reality come to have authority, and offering counters to mainstream management thinking;
- focusing on examining what is unsaid and listening to those who are usually unheard;
- an inclusive emancipatory intent; and
- an emphasis on reflexivity in the research process (Alvesson & Deetz, 2000; Johnson & Duberley, 2000; Willmott, 1995).

Rigg, Stewart and Trehan (2007) argue that 'traditional' HRD has been lacking in a critical perspective, and employs humanistic assumptions about individual identity and the self, and representationalist perspectives on the organization. Generally organizational interests dominate HRD (Callahan, 2007). A critical approach to management study views EE theory and practice 'embedded in the historical and cultural relations of power and domination' (Alvesson and Willmott, 2012: 41). Ezzamel and Willmott (2008) agree that a critical management focus offers an alternative perspective to what has been called more 'mainstream' or 'realist' forms of analysis, one which is not presented in opposition but rather to enrich knowledge.

Habermas contends that three cognitive interests underpin the production of distinctive forms of knowledge:

A technical interest, which is concerned to enhance prediction and control;

A practical (historical/hermeneutic) interest in improving mutual understanding; and

A critical interest in emancipation, which is concerned with the development of more rational social institutions and relations (Willmott, 2003: 94). CMS is particularly concerned with the second two.

Alvesson and Willmott (2012) contend that CMS is not 'anti-management'. Technical and instrumental reason is necessary, but it is not sufficient. But their distinction between 'critical' and 'conventional' management does pose a kind of dualism, which I would argue is more nuanced in practice and in research. Of course the term 'critical' has not been appropriated by 'critical management studies'. When conducting research, a 'critical' stance should be a feature no matter what the starting point of the researcher. Thus my first part of the literature review seeks to be critical in that authority is questioned, evidence is sought and assertions interrogated. However, it could be considered 'conventional' as it seeks to develop deeper understanding, but arguably from a largely 'technical' perspective when viewed through a CMS lens, in that some of the central premises of EE, such as the underpinning rationales of helping organizations to compete in the marketplace, have perhaps insufficiently challenged in the review of EE so far. The win-win discourse which characterizes much discussion on EE within a traditional management paradigm presents a decontextualized, depoliticized vision of the organization, similar to earlier work on the learning organization (Coopey, 1995).

Burrell (2001: 14-17) also notes that the term 'critical' is contentious. He identifies six strands of a critical approach: political – stressing the political nature of organizational life; iconoclastic - debunking of conventional myths; epistemological - questioning what is knowledge and how we achieve it; investigative- scrutinizing contemporary practices and institutions for how and why they operate as they do; revelatory - by attacking illusion there can be demonstration of what is illusion and what is truth; and emancipatory - critical theory has the freedom of the human spirit as its objective. He argues that the last two, whilst claimed to be part of a CMS perspective, are particularly problematic.

In this thesis I do not make a rigid distinction between ‘mainstream’ and ‘critical’ literature. However I do draw out some differences in assumptions underpinning different literature, and suggest some alternative critical and discourse perspectives through which to view EE. I wish to explore EE from some more ‘critical’ perspectives because I have an interest in the resources it provides to develop deeper understandings. But I was also influenced by the discussions that emerged from the focus groups that I held with NHS staff. Staff themselves were quite critical of ‘management’ and NPM practices, and I was interested in seeking alternative explanations for this. In developing the analysis of my data I sought different approaches that would help me develop deeper theoretical understanding. I did not set out on the research to initially take a solely ‘discourse analysis’ or ‘power’ perspective, for example, so the following discussion on discourse, NPM and resistance is necessarily partial, but has provided useful theoretical resources to help to deepen and broaden my critique and analysis of data. One approach is through the lens of discourse.

A discourse perspective on employee engagement.

Discourse analysis can help to deepen our understanding by contributing to alternative ways of describing and analysing the processes and practices that constitute organizations (Chia, 2000; Tsoukas, 2005; Grant & Hardy, 2003). There is a range of perspectives on discourse studies. They share in common the idea that discourse comprises ‘a set of interrelated texts, and related practices of text production, dissemination and consumption, that serve to bring an object or idea into being, thus playing an important role in constituting material reality’ (Grant et al., 2009: 214). Here ‘texts’ include not just the written word, but also the spoken word and visual imagery and other evidence. Discourses help form ‘social objects’ such as ‘organizations’ (Chia, 2000: 514). Chia (2000) contends that phenomena such as ‘the organization’, ‘the economy’, ‘the market’ ‘stakeholders’ etc.,

do not have a straightforward and unproblematic existence independent of our discursively-shaped understandings. Instead, they have to be conceptually fixed and labeled so that they can become the common currency for communicational exchanges. (Chia, 2000: 513)

This applies to concepts such as HRD and management development, which are brought into being through language, symbols and words (Sambrook, 2006). EE can be analysed as a discursive construction; rather than a pre-existing, social object, a discourse plays a role in constituting the material reality that is experienced as EE. The discourse operates in the

writing of books and research articles on the subject, in the websites of consultancy firms, and in the practice of HR, HRD and OD practitioners and consultants.

Chia (2000) cautions against ‘entitive’ form of thinking which is widespread in organizational theorizing, which treats organizations as independently existing social entities. This has similarities with the concept of reification. Whilst social phenomena such as ‘the organization’ are apparently solid, in fact the generic discourse processes serve to stabilize them. There is evidence of ‘entitive thinking’ around the issue of EE, which is treated in much literature as a given rather than a contested and nebulous concept. Whilst we recognize the debates about the construct in the literature, the discourse serves to ‘talk EE into being’. ‘Techniques of economic and organizational management rarely come ready-made. They have to be invented, implanted, stabilized and reproduced’ (Du Gay, 2003: 666). The targets and quality assurance mechanisms of health service management need to be embedded, they form part of the discourse, and are themselves shaped by the discourse.

Thus language does not simply reflect reality, but has a constructive, and also a regulatory and ideological function (Dick, 2006). Dominant discourses can be viewed as ‘generative mechanisms’ through which new ‘regulatory regimes’ executed by ‘expert groups’ become established (Reed, 2000). One can clearly see this occurring in the context of EE. EE is providing a convenient focus for the development of essential ‘new’ management interventions – presented as the ‘solution’, EE also acts to shape the ‘problem’. Expert groups such as consultants and management researchers, define both the problem and the solution, and become established and legitimated through this discourse. Discourses also help to determine social practices by shaping what can be said and by whom. A discourse rules *in* certain ways of talking about objects and subjects, and thus also rules *out*, limits or restricts (Grant et al, 2009). Dominant meanings emerge from ‘the power-laden nature of organizational contexts’, and the ‘discursive practices and rhetorical devices that are deployed in these struggles around meaning’ (Grant & Hardy, 2003: 5). So what is being ruled in and ruled out of the EE discourse, and what voices are being heard?

From a discourse perspective, an organization is not a stable or static order, but could be considered as an ongoing process of ordering (Doolin, 2003). ‘Organization’ can be viewed as a ‘multi-discursive set of strategic narratives’ (Doolin, 2003: 764). This seems a particularly apt way to describe such a complex organization as a hospital or health board.

The discursive space can also be quite permeable. 'The production of discourse in any social domain is always uncontrollable and unpredictable' (Dick 2006: 204).

Clegg et al. (2011) discuss the discourse around organizational change, which could as easily be applied to that around EE. They discuss Du Gay's (2003) critique of 'epochalist discourse', and note that much theorizing established sets of dualities and oppositions, which:

'relied on a logic of overdramatic dichotomization constructing opposed and ethically juxtaposed categorical imperatives, where the dice were clearly loaded in favour of change. In doing so, stark disjuncture and oppositions were deployed in simple narratives that politicians and their stakeholders could easily grasp, acting as catalysts for transformation. Simple answers positing universal and invariable managerial recipes'. (Clegg et al., 2011: 495)

This is an interpretation one could make in viewing the claims made for EE, for example its online presence in the websites of consultancy companies. However Clegg et al's scathing pronouncements are in themselves somewhat dramatic and dichotomized. One point worth considering is how far the 'marketing speak' of consultants is actually reflected in their practice.

Continuing in this vein, Du Gay (2003) makes observations about the 'evangelical strategy' of management writers such as Tom Peters, which could equally be applied to an analysis of much writing around EE. The idea of a 'threat' is raised, and the exhorting of the need to abandon old ways. What is needed to survive the threat is total transformation and regeneration. Salvation is possible, but only if you obey the 'prophet's commandments'. Du Gay (2003) remarks how

the 'management revolutionary' as charismatic religious prophet enthrones himself as moral judiciary. His claim is to unify, through the strategy of maximum businessness, that which 'bad old bureaucracy' is held to have set apart as separate spheres of existence: work and leisure, reason and emotion, public and private. For the epochalist prophet, this 'vision' or unified view of the world offers the route to salvation. (Du Gay, 2003: 669)

Such 'epochalist discourse' is a 'rhetorical device' which presents simplified and generalized versions of processes of 'change' through 'a simple and easily digestible set of slogans' which can be applied in similar ways to 'organizations and persons which are in fact of different quality and kind' (Du Gay, 2003: 671). The parameters for debate are set by offering simplified dualisms, which may be either 'bitterly pessimistic or dizzyingly optimistic' (Du Gay, 2003: 664). Du Gay and Clegg et al. here are themselves using some similar dramatic emphasizing, perhaps deliberately, to make their points. But the challenge

to be wary of ‘epochalist’ and over-dramatising pronouncements is a warning we can usefully heed when examining the discourses of EE. Claims are made that “no organization can afford to ignore EE”. You can’t not be ‘for’ it, in the same vein as motherhood and apple pie. So when Macleod asserts that ‘there are few industries that can afford to ignore EE’ (Macleod, 2010 online), the problem is defined by the solution.

Thomas (2003) presents the notion that discourses emerge and are developed via a framework of conjunctures, and through what he terms recontextualisation. He suggests that management academia, management consultancy and the ‘guru’ industry, and management practice, make up the three main conjectures in development of management discourse. ‘Recontextualisation’ of discourse occurs as it moves between discursive actors – from consultants to practitioners to academics. The ‘cultural authority’ of science remains a key part of the academic conjecture, whereas he sees a growing commodification of knowledge in what he terms the consultancy/guru conjecture. The conjuncture of management practitioners is more extensive and diverse. ‘Within this conjecture valuable discourse is that which ‘works’ on whatever pragmatic sense that entails. In many cases it seems that what works can be defined as that which enhances management control’ (Thomas, 2003: 788). (This has parallels with Macey and Schneider’s (2008) reference to EE as a ‘folk’ term, to refer to the approach as perceived by practitioners). The discourse of EE moves between these three ‘conjectures’ as it evolves.

Approaches to discourse studies can only be touched upon in this discussion. Doolin (2003) distinguishes between three main approaches to discourse studies, which he categorizes as functional, interpretive, and critical. One aspect which is of relevance to this study is Foucauldian critical discourse analysis, in which discourses are conceptualised as power/knowledge relations embedded in social practice, which are institutionalised and reproduced in social and material practices. Foucauldian critical discourse analysis ‘explores how individual actors are constituted as subjects through the reproduction of discourses that have deep political implications’ (Doolin, 2003: 755). Individuals come to understand the world in terms of the discourse and social practice. In a case study of the development of a new discourse in health care in the public sector in New Zealand he notes a number of different ‘professional’ narratives, which at times reinforced and at other times conflicted with one another (Doolin, 2003).

Reed (2000) however critiques a Foucauldian analysis, which asserts that reality is entirely socially constructed, in which discourses are assumed to take on an ‘object-constituting’ character as discussed above. Reed contends that this sole focus on meaning marginalizes the material aspects of economic and political reality, which act to constrain social action (Reed, 2000). Reed argues also for the role of agency in the ‘construction, reproduction and transformation of discursive formations’ (Reed, 2000: 52). Whilst discourses are important, they operate within ‘structures’, and these and the mechanisms through which they are generated are ‘fundamental to the constitution of our natural and social reality’ (Reed, 2000: 527). One such structure of significance to this study is that of ‘new public management’.

New public management, discourses and identities

The emergence of new public management (NPM) in the public sector has evolved since the 1980s, with increasing pressures for effectiveness and efficiency in service delivery. ‘Reinvention’ and ‘modernization’ of public sectors are sought through the introduction of business-style management, quasi-markets and targets, a focus on quality and measurement, and inculcation of new attitudes and values among professionals (Clegg et al., 2011; Learmonth and Harding, 2004; Brignall and Modell, 2000). The underpinning rationale is based on systematic modernism (Cooper and Burrell, 1998). ‘Systemic modernists seek to apply rationality to resolve problems in society (including organizational problems) because it is seen as neutral and value-free’ (Learmonth, 2003: 95). The process has served to redefine public services organizations, which have developed:

the apparatus of contemporary business management (e.g. knowledge management; organizational learning; competence-based leadership development; total quality management; business process re-engineering; culture change programs; human resource management interventionism, such as appraisal; strategic planning; mission statements. (Currie and Learmonth, 2010: 5)

These practices are now so common in the public sector that they are barely questioned. Harding (2004) contends that there is a belief that ‘better management’ is universally beneficial, but in fact entails ‘insidious forms of oppression’ which are ignored or covered up. Management theory as a set of technical activities can present a unitarist view of the organization as working towards common objectives, but in fact prioritises managers’ perspectives. This is in contrast to the view that an organization is made up of multiple and often competing discourses.

Through these management processes, NPM practices can be viewed as discourses, which serve to construct new identities in public sector workers. Thomas and Davies (2005) argue that they operate as 'disciplinary technologies', which seek to 'colonize worker subjectivities, such that they participate in their own subjugation, effectively removing worker opposition' (Thomas and Davies, 2005: 686).

But NPM is not the only discourse operating. Public sector services such as health care are complex, heterogeneous, deliver intangible services, have multiple stakeholders and operate in circumstances of high uncertainty (Brignall and Modell, 2000). This gives rise to ambiguities and tensions.

In the process of identity construction, other discourses (to NPM) within the organization and wider society also feed into an individuals' identity make-up and these may also act as a resource to contract a position of 'self as other'. Therefore NPM is one of a matrix of discourses vying for attention in the process of identity makeup. (Thomas and Davies, 2005: 690)

Thomas and Davies's (2005) research used interviews to focus on the process of identity construction to explore 2 main areas: the meanings ascribed to NPM by the individuals, and their own positioning within these meanings, which is an interesting parallel with the approach taken to this study.

Brignall and Modell (2000) explore one such 'disciplinary technology', performance management. Different stakeholder groups, for example professionals and funding bodies, have different definitions of performance. Funding bodies focus on efficient use of resources whereas professional groups of service providers tend to focus on non-financial aspects of performance, such as service to clients. The result is multiple definitions of performance, and conflicts between various stakeholders (Brignall and Modell, 2000). Decision making in public sector organizations is intensely political.

Another area, quality management as disciplinary technology, is addressed by Loughlin (2004). He is particularly scathing about the language of quality in the health sector, suggesting that language functions more as a mechanism of control of professionals' practices than a means of communication. What he terms 'linguistic inflation - the perpetual production of new pointless expressions and euphemisms' serves to 'render previously unproblematic areas of discourse barely intelligible to the uninitiated' (Loughlin, 2004: 33). He derides the lionization of management, in which managers are seen to have disinterested

concern for society, ‘whereas doctors’ resistance is demonized as self-interested attachment to their dominance’ (Learmonth, 2004: 10).

Organizations as sites of struggle

Much mainstream organization writing views organizations as places where members work towards collaboratively towards collective goals (Fleming and Spicer, 2007). But organizations can be viewed a ‘sites of struggle’ where different groups compete to shape the social reality (Grant et al., 2009). New organizational realities are formed by the process of constructing and sharing new meanings and interpretations (Tsoukas, 2005).

As Fleming and Spicer assert:

At the very heart of organizational life is the ongoing struggle between those in the corporation who seek to assert power and those who seek to resist and perhaps destroy this power. It is this struggle that gives organizations a sense of vitality and a life-giving political pulse. (Fleming and Spicer, 2007: 3)

Fleming and Spicer (2007) identify four distinct faces of power – coercion, manipulation, domination, and subjectification. Studying power as an ideational domination, for example, considers how a regime is established as taken for granted, normal and natural.

Subjectification includes systems of control, technologies of power/knowledge through which the voluntary compliance of employees is obtained. They suggest that each face of power points to a corresponding dimension of resistance – resistance as refusal, voice, escape and creation. In contrast to the dualism of power and resistance that characterizes much study of power in organizations, they explore the concept of struggle to focus on the interplay and mutual constitution of power and resistance.

Thomas and Davies (2005: 683), focusing on UK public services, also contest the ‘dualistic debate of ‘compliance with’ versus ‘resistance to’ to focus on resistance at a micro-level. They take a discursive approach to explore the production of meanings and subjectivities, and how individuals come to know and to challenge the ways in which their identities are constituted. Individuals are not passive recipients of organizational discourses, but resist conscription in complex and nuanced ways. Routinized, informal and often-inconspicuous everyday practices act as resistance, which serve to adapt and subvert dominant discourses. Individuals ‘pervert and subtly shift meanings and understandings’ as they recognize contradictions and tensions in their own identity performance (Thomas and Davies, 2005:

687). Despite asymmetrical relations of power, alternative subject positions are generated. Resistance is nuanced and 'multidirectional', and NPM contains paradoxes and contradictions, resulting in 'a web of contested meanings' (Thomas and Davies 2005). As O'Donnell, McGuire and Cross (2006: 5) argue, 'HRD exists in a continual state of dialectical tension' between serving the interests of capital or labour.

One way of exploring this web of competing discourses in the public sector is through the notion of professionalism. Currie and Learmonth (2010) contrast the emphasis on collegiality and team working which characterizes professional work, with managerialism. DiMaggio and Powell (1983) argue that organizations in similar fields tend to adopt similar structures, cultures and outputs, which they term 'institutional isomorphism'. This process has moved from the private sector to the public sector. They identify three mechanisms of institutional isomorphic change- '1. *Coercive* isomorphism, that stems from political influence and the problem of legitimacy; 2. *Mimetic* isomorphism resulting from standard responses to uncertainty; and 3. *Normative* isomorphism, associated with professionalization. The typology is an analytic one; the types are not always empirically distinct' (Di Maggio and Powell, 1983: 150). They suggest that structural arrangements 'can more likely be credited to the universality of mimetic processes than to any concrete evidence that the adopted models enhance efficiency' (Di Maggio and Powell, 1983:15). This perspective can provide an interesting framework for explanation of how management practices are adopted by organizations such as the NHS.

DiMaggio and Powell (1983) also explore professionalization, and suggest that the commonly ascribed contrast between organizational commitment and professional allegiance of professionals is less evident in contemporary organizations. Professionals move between similar organizations, 'a pool of almost interchangeable individuals' (DiMaggio and Powell, 1983: 152). Management is similarly professionalized. Thus the structures and processes of management across similar organizations is based more on isomorphism than assessments of what does and does not work well in practice.

Conclusions

In this review of literature I have provided an in-depth background to the construct of EE, and related concepts such as motivation and commitment, and the focus of HRD. I have also

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provided background to developments in health service management and the role of learning and development. Finally I have taken a critical and discourse perspective in EE and highlighted some critiques of NPM. This discussion has provided a background to research and theory relevant to this study. The next chapter examines the methodology for the research and the approaches taken to gathering and analysing data.

Table 8 summarises themes emerging from the literature review.

Employee and work engagement Concepts and constructs	Key themes and research findings
EE Definitions History Scope Claims made Practices	Employee engagement construct (Kahn 1990; Macleod & Clarke 2009; Allen & Meyer 1990; Gatenby et.al 2009; Macey & Schneider 2008) 2-way relationship – employer& employee (Robinson et al 2004) Contested meanings (Macey & Schneider 2008) EE measures (Harter et al 2002; Robinson et al 2004) Package of interventions (Attridge 2009) Drivers and barriers (McBain 2007)
WE Definitions, History, Scope Claims made Practices	Psychological connection to work; Vigour, Dedication, Absorption (Bakker et al 2011a) Job demands/personal resources model (Bakker & Demerouti, 2008) WE measures (Schaufeli & Bakker 2003)
HRD, L&D and EE	Definition and scope of HRD & EE (Shuck & Wollard 2010) Training and development contributes to EE (Robinson et al 2007) Employee development aligned to organization goals (Kontakos 2007) Integrated HR offer (Brewster et al 2007) Strategic HRD practices Meaningful work (Fairlie 2011; Chalofsky & Krishna 2009)
Employee Experience Leadership and Management	'Engaging' leadership, line managers key (Alimo-Metcalfe et al 2008) Team leadership (Parker & Griffin 2011) Shared leadership (Mathieu et al 2008) Leadership & empowerment (Kirkman & Rosen 1999; Shrivastava et al 2006)
Disengagement	20% disengaged (Attridge 2009) Costs of disengagement (Robinson et al 2007)
Locus of engagement Teams and work groups	Team as locus of engagement (CIPD 2011) Commitment to social foci (Meyer et al 2004) Perceived team support (Bishop et al 2000) Communities of practice and learning (Molbjerg Jorgensen 2011; Hatch & Yanow 2003) Social support from colleagues (Bakker & Demerouti 2008) Team motivation (Latham 2007)
Contexts of Engagement	Impact of context on workplace motivation (Chalofsky & Krishna 2009)
Motivation Commitment Psychological contract	Extrinsic & intrinsic motivation (Bakker et al 2011a) Employee commitment and motivation integrated. Affective, normative & continuance commitment (Meyer et al 2004) Meaningful work (Fairlie 2011) Organizational commitment features (Robinson 2003) HRD & commitment (McCabe & Garavan 2008) HRD & motivation (McGuire 2011) Psychological wellbeing correlated with performance (Robertson & Cooper 2010)

	Psychological contract (Guest & Conway 2002)
NHS Learning and development Culture Employee Engagement and NHS	The 'new NHS' – learning & development are key (Davis & Nutley 2000) Climate of change (Sambrook 2001) Learning organization and NHS (Sheaff & Pilgrim 2006) Psychological contracts (Davis & Nutley 2000; Murphy et al 2006s) 'Engaging' NHS management important (Alimo-Metcalfe et al 2009) Organizational culture transformation in NHS (Davies et al 2009)
Employee Engagement as Discourse	Discourses of HRD in NHS (Sambrook 2006) Technical and critical management knowledge (Alvesson & Willmott 2012; Burrell 2001) Critical HRD (Rigg et al 2007) Organization as discourse (Chia 2000) Discursive construction (Dick 2006; Reed 2000; Grant et al 2009; Thomas & Davies 2005) Discourses of change (Clegg et al 2011; Du Gay 2003)
New Public Management Organizations as sites of struggle	Modernization of public services (Currie & Learmonth 2010) NPM in healthcare (Brignall & Modell 2000) Disciplinary technology (Loughlin 2004) Resistance (Learmonth 2004; Thomas & Davies 2005) Organizations as sites of struggle (Fleming & Spicer 2007)

Table 8. Literature Review key themes

The review of literature provides a theoretical and conceptual underpinning for the empirical study and analysis of data. The next chapter discusses the methodology for the study. The themes identified from the literature review informed the development of the research questions and the framework for the conduct and analysis of the focus groups and interviews, as illustrated by the thesis conceptual framework Figure 3.

Chapter 5.1 Methodology

Introduction

Chapter 2 outlines the overall conceptual framework for the research, illustrated by Gummesson's (2000) model of the hermeneutic spiral, and discusses how preunderstandings move towards understandings, in abductive cycles of reasoning and data gathering. This chapter explains in more detail the approaches to gathering and analysing the empirical data. This elaborates on specific aspects of the second and third stages of the process illustrated in the thesis conceptual framework diagram (Figure 3).

Silverman (2005) argues that the key rule for writing the methods chapter is to spell out the theoretical assumptions. We need to recognise:

the (contested) theoretical underpinnings of methodologies,
the (often) contingent nature of the data shown,
the (likely) non-random character of cases studied;
the reasons why the research took the path it did (both analytic and chance factors).
(Silverman, 2005: 303)

I have started this discussion in Chapter 2. This chapter will further explore and seek to demonstrate the strengths and weaknesses of the research strategy, design, and methods. Issues of authenticity and ethical considerations are reviewed. The question of relevance of the research findings will be examined, and the possibilities and limitations of generalising, both to the wider organization and beyond.

Research approaches considered

The research for this thesis incorporates exploratory, descriptive, explanatory, and evaluative elements. As discussed, an interpretive social constructionist paradigm informs the research approaches to data gathering and analysis. The focus is on 'why' and 'how' questions. An interpretivist worldview sees the researcher as part of what is being researched. The objective is to understand meaning in specific situations, and to seek depth not generality of understanding. This lends itself to a qualitatively orientated inquiry.

The issues in this study could have been addressed in a number of alternative ways. The presenting issue emerged from the NHS Scotland staff survey, in which for example X% of

respondents to one of the questions in the recent survey indicated that they would not recommend NHS Lothian as a place to work. But why? When one starts to probe this question, multiple possibilities reveal themselves. It would have been possible to conduct a further quantitative survey, to drill down to particular groups of participants or look more deeply at a particular theme. For example, Alimo-Metcalfe et al. (2008), in their study to examine how quality of leadership affects organizational performance, chose a quantitative approach. They assessed the contribution of leadership to organizational performance by examining leadership quality and staff attitudes to work and well-being at work through a 'leadership climate and change inventory'.

But whatever is revealed by such an approach further questions would arise. A social constructionist approach allows for the development of rich description, exploration of competing perspectives, and of development of multiple layers of understanding. 'Constructionist research designs start from the assumptions that there is no absolute truth, and the job of the researcher should be to establish how various claims for truth and reality become constructed in everyday life' (Easterby-Smith et al., 2008:93). As Charmaz (2003:250) argues, 'Constructivism assumes the relationship of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims towards interpretive understandings of subjects' meanings'.

I was initially enthused about the potential to undertake an organizational ethnography, which has particular potential in the study of social relations in the workplace, and how people create and interpret meaning from their own and others behaviour (Easterby-Smith et al., 2008). Ethnographic studies can generate a rich, concrete, and complex account of the social world (Van Maanen, 1988). Organizational ethnography is exploratory research, so a wide-angle lens on the phenomenon of interest might prove a valuable approach in the initial stages of fieldwork, to gather data on a range of organizational variables, and identify a sample of key informants (Beattie, 2002). It became apparent that seeking ethical approval for this approach would be a lengthy process through NHS research procedures. Interviewing staff or conducting focus groups away from their workplace would require a lower level of ethical approval than research within the workplace, for example wards, where issues of patient confidentiality would emerge. Interestingly conducting interviews and focus groups with staff away from the ward was considered 'staff development' rather than 'research'.

Setting up a research project requires ‘harmonizing of *planned possibilities* with *workable, coherent practice*’ (Cohen and Manion, 2003:73, italics in original). The research had already been subject to lengthy delays in gaining access to the case organization to conduct fieldwork, and it took over 12 months to be in a position to begin to organize my data gathering. In consultation with the Lead Practitioner Research for Continuing Professional and Practice Development, NHS Lothian, a revised proposal was submitted which detailed fieldwork through interviews and focus groups.

There already existed a data set obtained through a quantitative survey, and some further analysis of this data was considered. Findings from this survey were already available as reports so it was decided that a further analysis of the quantitative data was not necessary, and that the research would concentrate on the gathering of new qualitative data. Silverman (2011) warns that a common mistake of novice researchers is to collect too much data, and indeed the data from the focus groups and interviews provided a sufficiently rich stream for analysis.

Qualitative research

Much research in the qualitative tradition adopts such an emergent design, bases its analysis around the fieldwork observations, and is geared to modest localised explanations (Denscombe, 1998). As highlighted, the approach to qualitative research in this study follows an iterative process, a step-by-step process of analysis and data collection, characterised by emergence, flexibility and cycles of inquiry/iteration (Pidgeon & Henwood (2009: 629). As noted in the earlier discussion on Gummesson’s (2000) notions of preunderstandings and the hermeneutic spiral, in a creative process, the research question is refined and sometimes changed entirely by the process of data analysis, and leads to further inquiry.

Pettigrew (2012) draws on Eisenhardt to argue that the qualitative researcher should provide:

‘evidence of transparency of theoretical and empirical positioning, transparency of research questions, of appropriate theory, of where the theoretical and empirical gaps are to be filled, of choice of cases, of data display and evidence, of transparency of method and forms of analysis, and evidence of substantiation of claims of scholarly contribution’ (Pettigrew, 2012: 3)

The approach to gathering and analysis of data is influenced by a wide range of theory. As Alvesson and Deetz (2000) argue, ‘method’ is more than simply ‘data management’, but it is a reflexive activity of interpretation, a process in which the theoretical, political and ethical issues are central (Alvesson & Deetz, 2000). Chapter 2 started to clarify the underpinning assumptions about the research purposes and processes. One can identify layers of theory involved in the entire research process for this thesis, which do not neatly fall into categories such as ‘methodology’ and ‘literature’. These are:

1. The research theories. These are the underpinning theories about research that had influenced and informed me as a researcher and the research process, the paradigms.
2. Theories about EE. In addition, theories about a key aspect of the research, the employee engagement construct, will influence the decisions as to methods and analysis of data.
3. Theories about HRD/L&D. Theories about HRD/L&D are also part of the background, both in general way and more specifically with respect to the examination of the relationship between EE and L&D in the organization.
4. Theories about researching HRD/Management. Research traditions in management studies.
5. Theories about new public management, culture, and NHS management.

Some of these theories contributed to pre-understandings informing the research, and some contributed to new understandings.

Case studies

The term case study is commonly associated with a location, such as an organization, but can also be a subunit of an organization, an individual, a group, or even an industry (Bryman and Bell, 2003; Maylor and Blackmon, 2005; Yin, 1994). Stake (2003: 141) argues that ‘with its own unique history, the case is a complex entity operating within a number of contexts – physical, economic, ethical, aesthetic, and so on’. Case studies can be intrinsic, instrumental or collective (Stake, 2003). In an intrinsic case study, the researcher seeks better understanding of the particular case. ‘The case is an object of interest in its own right and the researcher aims to provide an in-depth elucidation of it’ (Bryman and Bell, 2003: 54). In an instrumental study a particular case is examined mainly to provide insight into an issue or to redraw a generalisation. ‘The case is of secondary interest, it plays a supportive role, and

it facilitates our understanding of something else' (Stake, 2003: 137). Collective studies involve several cases. However not all research fits neatly into such categories, and the three notions of intrinsic, instrumental or collective case studies is 'heuristic more often than determinative' (Stake, 2003: 138). This research can be characterised as both intrinsic and instrumental.

The discussion on the case organization and the data for the study draws on several aspects as suggested by Stake (2003):

1. the nature of the case
2. the case's historical background
3. the physical setting
4. other contexts (e.g. economic, political, legal and aesthetic)
5. other cases through which the case is recognised
6. those informants through whom the case can be known. (Stake, 2003)

The physical setting is not explored in this study, but other aspects in Stake's list contribute to the study. 'Other cases' are not examined empirically but contribute through the review of literature.

Data collection

Silverman (2011: 42) identifies four major methods used by qualitative researchers: observation; analysing texts and documents; interviews and focus groups; audio and video recording (and other visual material). This research primarily made use of interview and focus groups, whilst texts and documents provided background information to the case organization. The bulk of 'researcher generated' data gathering through focus groups took place over a period of four months commencing in June 2010. This was preceded and followed by a number of one-to-one interviews. My initial meetings in setting up the research project can be considered as 'data' in as much as they contributed background information to the case study and its context.

Interviews

Data was collected from ten semi-structured interviews, based largely on a judgement and snowball sampling approach. Interviews were conducted with key informants, some prior to focus groups, to help to identify issues to build into the focus groups discussions, and some following on from the focus groups, to develop discussion on issues raised in the focus groups. The initial proposal suggested that this might involve inviting some participants

from focus groups to participate in a follow-up individual interview; however this was not followed up due to time constraints and amount of data already gathered.

The aim of qualitative interviews is to gain an understanding from the respondent's perspectives and worldview (Easterby-Smith et al., 2008; Miller & Glassner, 2004; Fontana and Frey, 2003). It is estimated that 90% of all social science investigations use some type of interview as a way of way of generating empirical data about the social world (Holstein & Gubrium, 2004). As a method of generating data, 'interviews reveal not only the substantive content of comments made by the respondents, but also how they use language, the stories and myths told, the humour, the naming and labelling of things, and the metaphors in common use' (Singh & Dixon, 2002: 126). Their advantage is that they allow for greater depth than some other methods of data collection. However, one criticism is that they are prone to bias and subjectivity on the part of the interviewer (Cohen & Manion, 1994).

Silverman (2005: 45) makes an important distinction, reminding us of the methodological issue as to whether interview responses are 'to be treated as giving direct access to "experience" or as actively constructed narratives'. A conversation is always a two-way process. From this perspective, the interviewer's questions are not a gateway to an authentic account, but part of the process of a collectively assembled narrative. Whilst interviews may vary from formal structured, semi-formal or free-flowing, all comprise an interaction between subject and interviewer, 'in which both participants create and construct narrative versions of the social world' (Miller & Glassner, 2004: 124). 'The narratives that are producedare all a product of the talk between interview participants' (Holstein & Gubrium, 2004: 141).

Miller & Glassner (2004) suggest a continuum of perspectives on interviews that ranges from objectivist to constructivist views. A positivist has as a goal the creation of the pure interview, which reveals data available through standardized interviewing, acting as a mirror of realities in the social world. The interview is a pipeline for transporting knowledge. Subjects are passive 'vessels of answers' (Holstein & Gubrium 2004: 141). Emotionalists on the other hand suggest that unstructured, open-ended interviewing can elicit authentic accounts of subjective experience. The interview is a social encounter in which knowledge is actively constructed.

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The interview is not so much a neutral conduit or source of distortion, but rather a site of, and occasion for, producing reportable knowledge ...respondents are not so much repositories of knowledge- treasuries of information awaiting excavation- as they are constructors of knowledge in association with interviewers. (Holstein & Gubrium, 2004: 141)

The interview setting is treated not as an arena for finding out facts, opinions and perceptions, but as a social event itself. Thus the interview is an empirical situation in itself (Thomas and Davies, 2005).

Radical social constructionists suggest that one cannot obtain knowledge of the real world 'out there' from an interview. However Miller & Glassner argue that information about social worlds is achievable through in-depth interviewing, a perspective with which I concur.

Research cannot provide the mirror reflection of the social world that positivists strive for, but it may provide access to the meanings people attribute to their experiences and social worlds. While the interview is itself a symbolic interaction, this does not discount the possibility that knowledges of the social world beyond the interaction is obtained. (Miller & Glassner, 2004: 126)

Miller and Glassner argue that the narratives which emerge in the interview context are situated in existing external social world of the interviewee, which exists outside of the interview itself. 'We argue not only for the existence of these worlds, but also for our ability as researchers to capture elements of these worlds in our scholarship' (Miller & Glassner, 2004: 131).

In conducting interviews, to succeed it is important for the researcher to establish rapport and trust with the interviewee, ensure and reassure about confidentiality, and not be judgemental (Miller & Glassner, 2004). In conventional survey interviewing, the interviewer must 'shake off self-consciousness, suppress personal opinion, and avoid stereotyping the respondent' (Holstein & Gubrium, 2004: 146). However, in what they term the *active* interview the interviewer converses with respondents. Interview participants are involved in *meaning construction*, not contamination.

The interviews conducted for this research were all semi-structured. Prior to the interview I identified a set of broad question areas for discussion – see Table 11 for details of focus group questions, which were also used as a starting point for the interviews. To preserve anonymity, Table 9 lists the job roles of the informants who were interviewed.

NHS Lothian Staff	External
Learning and Development manager Learning and Development manager Learning and Development manager Learning and Development manager IIP Manager HR Manager HR Manager	NHS Senior manager/L&D manager Learning and Development manager Scottish Government senior officer

Table 9. Interviewee job roles

Focus groups

A key source of data for this study was focus groups made up of different groups of staff. The purpose of the focus groups was to explore issues raised by the employee survey findings, and questions arising from the review of literature. The aim was to discuss issues around L&D and EE, staffs' perceptions about the concept of EE, their views on the opportunities for and barriers to learning and EE, and how to encourage engagement.

Focus groups enabled me to engage with a larger number of respondents than would be possible with individual interviews. Focus groups are informal group discussions with several participants, a moderator/facilitator, and emphasis in the questioning on a fairly tightly defined topic or set of issues (Wilkinson, 2004). Discussion is usually based on a series of questions - the focus group 'schedule' (Table 11); the researcher acts as 'moderator', ask the questions, facilitates group discussion, and encourages participants to interact with one another.

Focus groups are useful in elicitation of a wide variety of views on a subject, and the accent is upon interaction within the group and the joint construction of meaning (Bryman & Bell, 2003). They allow respondents to discuss the issues with one another, to test out shared understandings. As well as a convenient way to obtain the views of a larger number of participants than individual interviews, they open the possibility of the development of new ideas and insights. 'The dynamic quality of group interaction, as participants discuss, debate, and (sometimes) disagree about key issues, is generally a striking feature of focus groups' (Wilkinson, 2004:180). The dynamics could lead participants to define the issue in new ways

and find innovative solutions to problems (Bryman & Bell, 2003: 369). Similar to interviews, focus groups create a shared narrative, but several narratives are possible. The discussion can create a ‘synergistic effect’, which may lead to the production of more elaborated accounts than in individual interviews (Wilkinson, 2004: 180). Like interviews, focus groups can vary in the level of structure imposed by the facilitator, and can be more or less structured.

In all I ran 10 focus groups with a total of 52 Participants – see Table 10 for list of focus group participant job roles. The focus group participants were generally self-selected. Emails requesting participants were sent out to managers, who cascaded the requests, and participants volunteered.

Table 10. Employee Engagement Focus Group Participants job roles

F.G. Nurses/Allied Health Professionals	F.G. Administrative and support staff
Nurse Education Nurse Education Nurse Education Staff Nurse Staff Nurse Staff Nurse Staff Nurse Mental Health Staff Nurse Mental Health Staff Nurse Mental Health Charge Nurse Charge Nurse Charge Nurse Senior Charge Nurse Nurse Team leader Clinical nurse manager Auxiliary nurse Nursing Assistant Nurse Nurse Nurse Emergency nurse practitioner Orthopaedic nurse Mental health nurse Family nurse partnership District Nurse Community Mental Health Nurse GP Surgery nursing auxiliary GP Surgery Staff Nurse OT Community Mental Health Special needs Nurse Head of Manual Handling Radiographer Radiographer Radiographer Child Adviser Dietician Physiotherapist Physiotherapist Physiotherapist Physiotherapist Occupational Therapist Occupational Therapist Speech and Language Therapist Speech and language therapist	Personal Assistant Office Manager Team Manager Assistant Admin Assistant Medicine Admin Officer Medicine Medical Secretary Assistant Service Manager Executive Assistant

The focus groups all took place on NHS premises, they ran for about an hour and followed a similar format, and were all audio recorded. I introduced the focus groups by explaining the purpose of the research the contribution of the focus groups, and explained how they would run. I introduced myself and asked participants to give their name and where they worked. Table 11 shows the focus groups discussion questions and prompts. I started by giving a definition of EE, asked if they were familiar with it, and if they thought it was a relevant concept for the NHS. Using this shared definition, we discussed the drivers and barriers to engagement, and also their views on the findings of the 2008 staff survey, an extract of which was tabled (Table 12). We then discussed their experience of L&D in the organization, and whether it could contribute to engagement. I facilitated the discussion, using the list of questions and prompts such as “could you say a bit more about that?” I was active in acknowledging contributions, rephrasing, repeating back. In some cases the conversation flowed, and in others I had to be more proactive. I tried to involve everyone by asking direct questions to some individuals.

Bryman & Bell (2003) suggest some limitations of focus groups include that they can be difficult to organise, lack researcher control, data may be difficult to analyse, and large amounts of data are generated. In the event I found the groups reasonably easy to organise. Quite a number of potential participants did not turn up on the day, but 52 participants was still a good response rate. I did not send out a reminder near the date, which in hindsight may have been prudent.

Sometimes focus groups are conducted by two facilitators – one guides the discussion and the other records observations on the discussion, including names of different participants, noting non-verbal communications, etc. With hindsight it would have been useful to have a fellow facilitator. I found it difficult to facilitate the discussion and make notes at the same time, and therefore did not record the names of each contributor during the discussions. Consequently when I played back the recording of the group it was not always clear which person was speaking. Although it was possible to some extent to identify people by their voices, in the larger groups in particular this was not always possible. I could have been helped by preparing a response sheet prior to the groups in which I noted who was speaking. In the analysis of the focus group data I decided not to try to identify individual participants but to label them according to their professional group.

Focus group questions Employee Engagement July/August 2010

1. Introduction – welcome and thanks.

1. **Background to the research.** The purpose of the study is to explore the link between employee engagement and learning and development within NHS Lothian. The aim of the study is to develop a more in-depth understanding of staff experience of the drivers and barriers of employee engagement, and to highlight implications for learning and development in the organization. The views and opinions of staff are central to this study. No right answers, want to explore ideas.

1. **How the focus group will run** – I will facilitate, list of questions, discuss, qualitative analysis of themes and issues arising. Record and notes.
2. **Ground rules** – Confidentiality. Don't identify individuals or individual viewpoints. Use discretion about sharing information on the discussion – don't disclose any personal or possibly contentious matters. Let people have their say – don't interrupt.
3. **Introductions – group members.** Any questions

2. Employee engagement – the concept of EE suggests that how you think, feel and behave is directed towards achieving the goals of the organization. 'Employee engagement is a workplace approach designed to ensure that employees are committed to their organization's goals and values, motivated to contribute to organizational success, and are able at the same time to enhance their own sense of well-being' (MacLeod and Clarke 2009). An engaged employee experiences a blend of job satisfaction, organizational commitment, job involvement and feelings of empowerment. (On flipchart).

Employee engagement in NHS Lothian

Are you familiar with the concept of EE?

What contributes to EE in working within NHS Lothian?

What gets in the way?

Give positive and negative examples.

What does employee engagement mean to you?

What supports your motivation and focus to do your best in your job?

Follow up – Is it a relevant concept in the context of health service work?

Do you use other terms to mean the same thing as EE? How does it relate to other relevant concepts e.g. professionalism?

Drivers of engagement – are these evident in NHS Lothian?

Shared vision. No 'blame culture' – learn from mistakes. Clear systems, procedures and guidelines.

Supportive management. Engaging leaders. Good training and development and HR policies and practices. The need for active involvement of line managers.

A 'learning culture', supporting of adaptability, experimentation, learning and innovation.

3. The survey results. What are your views on these findings?

Three key areas of EE for NHS Scotland. Table 1. Table 2

4. How can learning and development support you to do your job?

Some studies show that L&D is an important contributor to EE.

L&D – career development, training, professional development. Induction, PDP, performance review, opportunities to receive training to improve your skills in your current job.

L&D formal processes and opportunities.

Informal/experiential learning – learning on the job, learning from one another, learning from experience. Learning organization?

6. How can L&D contribute to EE in NHS Lothian?

From your understanding of EE, what contribution could L&D in NHS Lothian make to EE?

Suggestions for improvements? Issues of concern?

Table 11. Focus group questions.

Table 12. NHS Scotland Staff survey 2008 extract for focus group
(Over)

Employee Engagement

Employee Engagement Index

For the 2008 staff opinion survey for NHS Scotland, we have asked questions which go beyond looking at how satisfied employees are, to looking at those employees who go the extra mile for their Board. We have broken this down into three key areas:

- 1) SAY - Speaking positively about their Board
- 2) STAY - Commitment to their Board
- 3) STRIVE - Extra Effort

These 3 areas combined make up what we call 'Employee Engagement'.

The following questions measure Say, Stay and Strive in the NHS Scotland Boards.

Engagement Index Questions	Board % positive	NHS Scotland % positive	2006 % positive	Benchmark % positive
I would recommend NHS Lothian as a good place to work*	48	55	42	62
I intend to still be working within NHS Lothian in 12 months time	76	77	71	69
I am happy to go the 'extra mile' at work when required	83	85	-	89
<i>Employee Engagement Score:</i>	69	73		

Drivers of Employee Engagement

This section of the report should be read in conjunction with the detailed Key Driver Analysis (KDA) report. KDA is a statistical tool used to help focus on those aspects of working for NHS Scotland, which have the greatest impact on employee engagement. The dashboard below summarises those aspects by listing the questions from the survey that have the greatest impact on employee engagement.

The top six significant questions identified by the statistical analysis on the core questions are listed below. These have the highest impact on employee engagement and are listed in order of importance.

NHS Scotland Staff Opinion Survey 2008 Dashboard

Drivers of Employee Engagement	Board % positive	Variance from:		
		NHS Scotland % positive	2006 % positive	Benchmark % positive
I am treated with dignity and respect in this organisation	57	-2	+2	-14
NHS Lothian manages change effectively	21	-6	+3	-11
My job makes good use of my skills and abilities	71	-2	-3	-2
I am comfortable with the level of pressure placed on me in my job	53	-3	-7	-7
There are sufficient opportunities for me to receive training to improve my skills in my current job	56	-1	+2	0
Health & Safety is taken seriously by this organisation	61	-4	-5	-11

*Please note: the text for this question has changed since 2006.

Sampling

It is important to have a limited body of data in order to achieve an effective analysis in qualitative research, and the researcher should aim for depth rather than breadth (Silverman, 2011). Silverman (2011: 44) suggests that ‘authenticity’ rather than sample size is an issue in qualitative research, ‘the aim is to gather an ‘authentic’ understanding of people’s experiences’. Rocco (2003) suggests that sampling information should include the rationale for the type of sample used, information on how the actual study participants were selected and demographic information about the participants. A number of possible approaches to sampling for this study were considered:

1. Research one group of staff e.g. nurses, either across several sites in the organization or in one or two sites;
2. Research a cross section of staff within one site;
3. Research a cross section of staff across the organization.

Given the scope and nature of this study (an exploratory, qualitative study), and following discussion with the Lead Practitioner for Research, the third option seemed most suitable. The issue of seeking a ‘representative’ sample is less significant in qualitative research; nevertheless this approach provided a cross section of staff working within a range of functions. Purposive sampling demands that we think critically about the parameters of the population we are studying and choose our sample case carefully on that basis.

In NHS Lothian, approximately 83% (£555m) of the workforce budget at the time of the research was for clinical staffing, with 18% (£113m) for non-clinical staff, such as medical secretaries, domestic staff, catering staff and managers (2008-9 Workforce plan). By far the largest section of the workforce is made up of nursing and midwifery staff. Overall NHS Scotland workforce summary by staff grouping as at 30th September 2009 indicates the following workforce in order of size.

Nursing and Midwifery	40.4%
Administrative services	18.2%
Support Services	12.1%
Medical (including GPs)	9.8%
Allied Health Professionals	6.9%

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Smaller percentages are taken up with dental, medical and dental support services, other therapeutic services, personal and social care, healthcare science, and emergency services. These figures are largely echoed in NHS Lothian's staffing make up- see Chapter 3.

The sampling approach to the focus groups was a stratified sample, and to some extent a convenience sampling approach. In qualitative research, rather than a representative sample, an iterative approach will determine the ultimate size of the sample. This entails gathering data until little new data is being generated. However, care was needed to ensure that this potentially did not become too large for the parameters of the study. Clearly there were initially potentially a large number of different staff groups that could be part of the study. It was decided to organise ten focus groups, made up of a range of staff from the five groupings above, and in a range of contexts (for a number of different institutions and primary care). As nurses and allied health professionals are clinical groups who work closely, one set of focus groups was aimed at these two groupings. The other set was for administrative and support services. I was advised that it would be too difficult to get groups of Medical staff (doctors) together in an invited focus group, and it was suggested that I would attend an appropriate event such as a meeting or training session and try to run a short group with them. However in the end it was not possible to organise this within the timeframe of the data collection period.

Documentary data

Documentary data which informed the study was largely from sources that are available online, for example on the NHS Lothian website. This consisted of web pages and PDF documents. For example, all Board meeting papers are available online, and this provides a wealth of data such as strategic planning documents, which are all presented to the Board. There are also information pages about topics such as history, structure, staffing, staff governance etc. Other websites consulted for example included NHS Scotland pages on the Scottish Government websites, NHS Education Scotland, and relevant bodies such as the Royal College of Nursing.

Issues of validity and reliability

Lincoln and Guba (1985) suggest that the reliability, validity and generalizability sought from quantitative research can translate into three criteria for qualitative research - credibility, dependability, and transferability. These provide useful guidelines for planning and conducting the research. On the issue of validity in constructionist design, Easterby-Smith et al (2008) quote the three criteria mooted by Golden-biddle and Locke (1993) – authenticity, plausibility, and criticality. Authenticity - the researcher has a deep understanding of what is taking place in the organization; plausibility – the research links to some ongoing concern /interest among researchers; and criticality - requires readers to question taken-for-granted assumptions and thus offer something genuinely novel. Again these provided useful guidelines to frame the process, planning and reporting of the research.

Yardley argues for the following considerations, which it is hoped that this report adheres to:

sensitivity to context – in terms of related theory, epistemological commitments of the research and socio-cultural context of data collection;
Commitment, rigour, transparency and coherence – in terms of researcher engagement with the study, completeness of data collection and analysis, careful description through the analysis; and
Impact and importance – in terms of the substance and worth of the work in relation to the earlier theory and the specific issues being explored. (Yardley, 2000: 5)

It is usually not the purpose of case study research to generalise from a particular case, but a degree of theoretical generalizability is often claimed (Bryman & Bell, 2003). Here, intensive examination of a single case is conducted in the light of a theoretical analysis. The crucial question is not of whether the findings can be generalised to a wider universe, but how well the researcher generates theory out of the finding.

The central issue of concern is the quality of the *theoretical reasoning* in which the case study researcher engages. How well do the data support the theoretical arguments that are generated? Is the theoretical analysis incisive? For example, does it demonstrate connections between different conceptual ideas that are developed out of data? (Bryman & Bell, 2003: 56)

The theoretical analysis for this thesis has been outlined in preceding chapters. Chapter 7 presents a discussion of the data, based on the findings in the review of literature and reflecting on the research questions, which tentatively suggest some wider generalization.

Lee & Fielding (2009) discuss ‘analytical-procedural adequacy’, by which researchers document their conduct at each stage it makes the process transparent. This study and its

reporting attempts to adhere to these guidelines. Silverman (2005) suggests four criteria for evaluating quality in qualitative research, which informed the process of the research:

1. How far can we demonstrate that our research has mobilized the conceptual apparatus of our social science disciplines and, thereby, helped to build useful social theories?
2. How far can our data, methods and findings be based on a self-critical approach or, put more crudely, counter the cynic who comments ‘sez you’?
3. To what extent do our preferred research methods reflect careful weighing of the alternatives or simple responses to time and resource constraints or even an unthinking adoption of the current fashions?
4. How can valid, reliable and conceptually defined qualitative studies contribute to practice and policy by revealing something new to practitioners, clients and /or policy –makers? (Silverman, 2005: 229)

Ethical considerations

The research complied with ethical guidelines for research approved by the Research Ethics Committee of the College of Humanities and Social Sciences, The University of Edinburgh. The framework for the ethical conduct of research within the University’s College of Humanities and Social Science is guided by principles of dignity, respect and care for others, honesty, integrity, objectivity, accountability, openness, and leadership.

Transcripts were kept on a computer and protected with password-only access. Other documents were kept in a filing cabinet. Every effort was made to ensure that individuals contributing to the research cannot be identified in the report of the research. Where it might be appropriate for individuals’ views to be identified, their permission would be sought. Appendix 2 details the participant approval information and consent form which each participant was asked to complete.

The next section details the approach taken to analysis of data.

Chapter 5.2 Methodology: Data Analysis

Introduction

In quantitative studies data management is considered before data collection, and largely dictates the different approaches that can be taken to data analysis. As discussed, qualitative research on the other hand tends to be more ‘messy’, following an iterative, cyclical process, and data management and analysis are interwoven. This calls for different approaches to data collection, data management and data analysis.

In contrast to the typical linear structure of the quantitative research task (find or develop a theory, gather empirical data, confirm or disconfirm the theory), qualitative findings often emerge through a complex process of gradual evolution, driven by the interaction between theory and data. (Sinkovics & Alfoldi, 2010: 109)

Some argue that qualitative data analysis should commence from the beginning of the research. Fieldwork and reading the literature occur concurrently, data (including the literature, which can be regarded as ‘data’) is studied repeatedly in a process of ‘making sense’ (Liamputtong, 2009: 133). The analytical process of abductive reasoning involves seeking patterns in data on the basis of theoretical understandings. There is a process of repeatedly alternating ‘between (empirically-laden) theory and (theory-laden) empirical facts’ (Alvesson and Sköldberg, 2009: 5), which is the process that I followed, as illustrated in the earlier conceptual framework model in Chapter 2 (Figure 3).

Data management and analysis

All of the 10 focus groups and most of the interviews conducted for this study were recorded on a digital voice recorder, a common approach to data management. I sought permission to record from respondents, and during the focus groups and interviews I was not aware of the recording device being intrusive, but the fact that it may have had an impact needs to be borne in mind. However for a focus group it would have been very difficult to make sufficient notes to record the conversations, particularly with only one researcher present.

For those interviews that were not recorded, I took notes during the interview then wrote these up in more detail after the interview. However the recordings generated much more useful data than notes, enabling the whole discussion to be captured. I was aware as I took

notes in the interviews that I was not able to capture all the content in detail, and also missed out on a number of ‘choice quotes’ that I would have liked to take down verbatim.

I initially attempted to transcribe some of the recordings myself. It is often suggested that the researcher should transcribe the data themselves (e.g. Liamputtong, 2009), so as to keep as close as possible to the original source without an intervening interpreter. However I found that typing up the transcripts myself was too slow, and therefore arranged for the recordings to be sent as DSS digital files for transcription by an experienced research secretary. In order not to distance myself from the original source of the data, following the return of the transcripts, I read through the transcripts whilst listening to the audio recording of the events. I used this time to correct errors in transcription, and to begin the process of analysis. The secretary had had some difficulty in hearing or understanding some parts of the interviews or focus group discussions in a few places. This was due to difficulty in distinguishing speakers during the focus group discussions, respondents speaking fast or quietly, background noise, or what I assumed was lack of familiarity with some of the terms used in discussion. I was able to fill in the transcripts for most of the discussions, although there were a very few places where I also could not understand what was being said.

During this process, I noted as memos my observations and thoughts on themes which emerged. During this time I also went back to the literature and did more reading and writing up for the literature review. I devised a series of codes in a coding frame and coded the transcripts using data analysis software. This constituted the first stages of the analysis. After writing up notes on the initial analysis of findings, I then went back over the transcripts again to conduct a deeper conceptual analysis. As there had been a gap of some time between gathering the data and the initial transcript editing and analysis, I listened to the recordings for a third time whilst going over the transcripts, and then revised the initial coding. This whole process is described in more detail below. I considered a variety of approaches to data analysis. I rejected conversation analysis (Clayman and Teas Gill, 2009), as not really suitable for a focus group. I was interested in some form of discourse analysis, but I decided initially to follow guidance on coding as noted in the next section.

Guidance on analysis of qualitative data

There is a wide range of suggestions as to how to code data for qualitative analysis, including different levels of analysis, and managing an ongoing process of analysis. Generally coding takes place in stages, and moves from a ‘descriptive’ focus to a stage of ‘analytical’ or ‘theoretical’ coding (Gibbs, 2011). Working closely thus with the data allows a move away from description to work at a conceptual level; ‘the process of theorizing thereby explaining what is actually going on rather than describing what is happening’ (Kenealy, 2012: 4099).

The initial literal focus on the data can be on words, dialogue used, actions, settings, and systems. This moves into interpretation – focusing for example on such things as implicit norms, values, rules, mores, of how people make sense of phenomena (Mason, 2002). In addition, a reflexive focus examines the researcher’s role in the process, and how the intervention by the researcher (for example the interview) generated or influenced the data.

Rapley (2011) seeks to draw out common themes from for qualitative data analysis, arguing that different approaches share some resemblances, in that they seek to move from the particular to the abstract. Analysis commences with a close inspection of the data-

This close inspection is used to discover, explore and generate an increasingly refined conceptual description of the phenomena. The resulting conceptual description therefore emerges from, is based on, or is grounded in the data about the phenomena. The focus shifts from: What is said by participants, what you’ve observed them doing or what you read in a text (the level of description and summary): to Exploring and explaining what is ‘underlying’ or ‘broader’ or to ‘distil’ essences, meaning, norms, orders, patterns, rules, structures, et cetera (the level of concepts and themes. (Rapley, 2011: 276)

Rapley’s analysis is helpful for those researchers such as myself who do not want to follow the precise procedures of approaches such as grounded theory, but rather to take an approach that draws on different theories of qualitative research. For example, in a grounded theory approach the initial codes are also largely ‘in-vivo’ codes – codes generated from the participants (Kenealy, 2012). However other approaches suggest that codes can also evolve from prior assumptions and theoretical themes drawn from the literature. This is the approach that I chose to take.

Various term are used to refer to the stages of coding. First stages are called initial coding (Liamputtong, 2009), topic coding (Sinkovics & Alfold, 2010), or open coding (Kenealy,

2012). During the early stages of coding the data can be coded to initially generate as many codes as possible. 'This process continues until new incidents do not warrant new codes (as new categories) because they fit into existing coded categories' (Kenealy, 2012: 413).

Liamputtong (2009) sees this more as an initial thematic analysis - the researcher searches across the data set to find repeated patterns of meaning. Topic coding requires material to be coded into a subject-based structure, which will help to make sense of rich and complex data (Sinkovics & Alfoldi, 2010).

The next step is referred to as axial coding (Liamputtong, 2009), analytical coding (Sinkovics & Alfoldi, 2010), or selective coding (Kenealy, 2012). Selective coding involves grouping the empirical data under conceptual (explanatory) headings rather than descriptive ones. In grounded theory the stage of theoretical coding would be followed by a final step termed theoretical coding. At the point in the research when no new categories emerge, and all new data fits into existing codes, saturation occurs (Kenealy, 2012). Others approaches merge these second and third stages into a single second stage, but the concept of saturation is quite widely used. Axial coding also allows researchers to connect different codes identified in the initial coding into categories and sub categories, which are identified by repeated reading and re-reading of the data (Liamputtong, 2009). Analytical coding relies on the theoretical and conceptual inputs into the research, as well as the empirical data, 'coding the data into an evolving structure based upon the analyst's *ongoing interpretation* of the action (Sinkovics & Alfoldi, 2010: 123). Analytical coding is:

structured around the intended contribution of the study, its purpose is to generate a refined, integrated and theorized coding scheme, building on the outputs of the topic coding process and the progressive interaction between theory and data. (Sinkovics & Alfoldi, 2010: 123)

Rapley's (2011) very practical guidance filters out the essence of the process common to a number of approaches, and more precisely reflects my experience. He suggests some fundamentals to data analysis are:

Start with a close, detailed reading of a sample of the data;

Read and systematically label your archive of data;

Reflect on what you have done (give some key examples, write a sentence to explain);

Review and refine your labels and labeling practices (try to combine initial labels, look for links, repetitions, and exceptions. Shift from descriptive labels to more conceptual, abstract and analytical labels (Rapley, 2011).

Employee engagement, learning and development in an NHS organization

Lofland, Snow, Anderson and Lofland (2006) suggest that conceptual analysis can seek meanings, reflecting on what directs participants' actions, what concepts they use to understand their world, and what meaning or significance it has for them, for example.

Ryan and Bernard (2003) suggest that the analysis seek out:

Repetitions – words that occur a lot – can be indicated by a word search

Concordances (meanings can differ)

Indigenous typologies (in vivo)

Metaphors and analogies

Transitions (pauses, sections)

Similarities and Differences

Constant comparison (with other sections in the data; how is this similar/different?)

Linguistic connectors

Because, before, after, next, closeness, examples

Missing data (what is omitted)?

My experience was that the process did not occur in distinct stages of description followed by conceptual analysis. During the initial stages of editing transcripts, identifying codes and coding the data, I introduced some analytical codes as well as codes that emerged from my reading of the data. Insights occurred during the conduct of the interviews and focus groups – the process of analysis beginning during the 'data collection' phase. This fits more with the notion of abductive reasoning as discussed earlier.

Gummesson (2000) argues for *theoretical* sensitivity during the analysis, and suggests that the researcher must be prepared to change their theoretical paradigm if 'reality' requires them to do so. Rapley suggests that you be prepared for uncertainty and to be led down novel and unexpected paths:

Potential ideas can emerge from any quarter – from your prior and ongoing reading, your knowledge of the field, from engagements with your data, from conversations with colleagues, and from life beyond academia – and from any phase in the life-cycle of the project. Whatever you do, remember to write it down! (Rapley 2011: 279)

CAQDAS

I decided to use computer aided qualitative data analysis software (CAQDAS) to help the process of data management and analysis. CAQDAS has potential to help to make the non-linear qualitative research process more systematic, and add both flexibility and rigour (Sinkovics & Alfoldi, 2010), and can assist the constant comparison or triangulation between theory and data. The software does not take over the researcher's skills in analysing and

interpreting data, but it can provide a way of auditing the research process, making the process more manageable and also more transparent. One can ensure that at each stage of the research that the basis of interpretation is made clear, whilst ‘recognizing and identifying the constraints applicable to given interpretations’ (Lee & Fielding, 2009: 536). Whereas for quantitative research one needs to ensure replicability, for qualitative research precise replicability is not possible, and one needs ‘precisely to explain the idiosyncrasies of each qualitative research projects that *preclude replicability*’ (Sinkovics & Alfoldi, 2010: 115).

Typically qualitative research generates large amounts of data, management of which can be helped by CAQDAS. Data may be acquired chronologically, but analysis is usually topic-oriented, with the analyst trying to identify themes emerging from the data.

Because data collection and data analysis are intertwined in qualitative research, early decisions or non-decisions about how to handle data can have longer-term analytic consequences. (Lee & Fielding, 2009:5 33-4)

Content analysis is easily aided by CAQDAS. An index is created which can provide a list of words in a text, and also the position of each. Concordance analysis can also show the immediate context of a word, and also seek out co-located words (Sinkovics & Alfoldi, 2010). I considered relational content analysis, which looks at links between sentences (Franzosi, 2009). However I felt that this approach was too mechanistic and not in keeping with my interpretive stance. Theory-building software emphasizes relationships between the codes, while still supporting code- and- retrieve work.

The idea is to develop higher order classifications than those derived directly from the data, formulate propositions which fit the data and test how well they apply, and/or visualize connections between codes as a stimulus to conceptualization. (Lee & Fielding, 2009: 532)

These tools and procedures support interpretive analysis, but there are some controversies over their use. In particular, we need to be alert to the effect that the ‘tools’ have on the data and its analysis.

I uploaded the edited transcripts into Dedoose, an online mixed methods data analysis system. As noted I took an active stance, reading through each transcript, and generating a range of codes of theoretical and data-driven codes, which I applied to the transcripts by defining excerpts to each code. Dedoose allows ordering of codes as root codes and ‘child codes’, which allow more detailed sub-coding. As noted, there are different views on how many codes to have – Dedoose suggests not more than 30. I came up with 28 codes in total

(see Table 13).

‘Child codes’ were used as a way of thematic ordering of data. They are not sub-codes in a hierarchical sense, but a way of categorizing the different aspects around a theme. For example under the general (root) code of ‘Employee engagement’ I had two main root code areas and several sub-codes. Under ‘Employee engagement comments’ root code I had – General comments on EE; Familiar with the term EE; Barriers to EE; and Drivers of Engagement. I had a second EE root code ‘Locus of Engagement’, under which I had – General comments; Engaged with Co-workers/team; Engaged with the organization; Engaged with patients.

The initial coding is illustrated in Table 13 in a ‘coding frame’. I constructed two of these, one for data from the focus groups and one from the interviews. To facilitate presentation and analysis of the findings and link to the research questions, I organized this into three overarching groupings – Employee Engagement, NHS Lothian, and Learning and Development, which are highlighted by a different background colour in the table.

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Root Code title	Child Code title (if applicable)	Code Descriptor	Reason for code	Number of excerpts
Employee Engagement comments		General comments on EE	Participants in both focus groups and interviews were asked to comment on the concept of EE.	84
	Familiar with the term EE	Are participants familiar with the term EE, and other terms they use. Comments on measurements of engagement	I was interested to find out what people knew about the concept of EE and identifying similarities and differences.	21
	Barriers to EE	Comments on what gets in the way of EE	Understanding the barriers and drivers to EE were a goal of the research	55
	Drivers of Engagement	Comments on things that facilitate EE		49
Locus of Engagement	General comments	What people say about the locus of engagement	An emergent theme from the focus group discussions which also appears in the literature	11
	Engaged with co-workers/team	Locus of engagement is with co-workers or the team	This was mentioned a lot in the discussions	19
	Engaged with the organization	Locus of engagement is NHS Lothian	EE literature suggests that EE is with the organization goals.	23
	Engaged with the patients	Locus of engagement is patient care	An emergent theme	28
NHS Lothian		Views on NHS Lothian	It was interesting to note views on NHS Lothian as it is the employing organization.	67
The NHS		Comments on the NHS, history etc.	A range of views were expressed on the wider context of the NHS	14
The current climate	Cuts etc.	Also includes the policy framework	An emergent theme	85
	Targets.	Working to targets, often set by Government, e.g. waiting times. An emergent theme.		45
	Workload, pressure	Comments on workload and pressure	An emergent theme	52
Organizational change		Comments on organizational change	An emergent theme	11
	Change management	Comments on how change is managed	An emergent theme	29
Comments on management		Comments on management and managers	An emergent theme and also one which features in the literature of EE	64
	Not being listened to		An emergent themes	18
	Criticisms of management	Comments critical of management and managers	An emergent theme	60
	Bullying		An emergent theme	9
	Teams	Comments on teams, multidisciplinary working etc.	An emergent theme	14

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Learning and Development		General comments on learning and development	Obtaining views on L&D were one of the goals of the research	152
	Mandatory training	Comments on mandatory training	An emergent theme	53
	Informal learning, sharing	Comments on informal learning, sharing, creativity etc.	An emergent theme	36
	Management development	Comments on management development	An emergent theme	9
	IIP	Comments on Investors in People	An emergent theme	19
	Resources	Comments on resourcing L&D e.g.. finances, absence cover	An emergent theme	30
	SHRD, managing L&D	Comments on managing L&D and SHRD	An emergent theme	3
	Skills	Comments on skills, what use the organizations makes of skills, skills training.	An emergent theme	37
Great quotes		Overall good quotes.	Dedoose suggested this	79

Table 13. Data analysis coding frame

Table 13 lists the number of excerpts within each code. In some cases this gives an idea that this was a topic that was mentioned quite a lot. In the case of the code 'Learning and Development' the 152 excerpts might indicate that this code is too broad, despite the fact that I included 7 child codes in this category, in addition to the root code. Some themes got only a few mentions, but were deemed significant for a variety of reasons; either they linked to theoretical themes which were pre-determined or emerged, or they seemed very significant to the respondents. Some excerpts were coded under more than one category, or sections of excerpts in one code were included in other sections of code. Whilst this made sense during the process of coding (more than one meaning could be interpreted from a statement), where more than one code was ascribed to an excerpt I had to be careful to avoid repetition in reporting of data.

In the next stage of analysis I went through all the excerpts for each code, and sought to summarize 'key points'. To illustrate these I chose a selection of excerpts, an illustration of which is presented in the Appendix 3. To hone down this data further for presentation and deeper analysis, I chose to categorise the 'key points' into a simple likert type scale, summarized as 'positive', 'neutral, descriptive, normative', and 'negative, problems and difficulties', an example of which is presented in Appendix 4. The aim of this was to help with interpretation and presentation of core meanings from the data, and illustrate strength of feeling. The discussion in Chapter 7 is a continuation of the process of analysis, reflecting on what was revealed from the layers of analysis of the empirical data.

Problems of de-contextualising the discussion can arise when using transcripts only, and is it may be important to understand quotes into context. However I had listened to the recordings at the same time as examining the transcripts, so was aware of the context, and the context was generally bounded by the time limit of the focus group and the suggestions. Where is it helpful, for presentation of findings I have noted comments within a stream of text.

After discussing key themes, I went back to the extract and performed some simple discourse analysis, to generate new analytical categories based on interpretation of discourses (Potter, 2009).

Conclusion

This chapter has explained the approach taken to the gathering and analysis of data and the underpinning rationales informing the empirical study. The next chapter will present the findings, and this will be followed by a discussion reflecting on the findings.

Chapter 6.1 Findings and analysis - Focus groups

Coding

As noted in the previous chapter I organized the codes into three overarching groupings – Employee Engagement, NHS Lothian, and Learning and Development. The column ‘Number of Excerpt’ here lists the number for the focus groups only. Key points within each code were then identified by a further process of analysis, as illustrated in Appendix 3 and 4. In this chapter I summarise and discuss the key points. There is inevitably some overlap within and between codes, so for the presentation of findings and analysis I have combined codes where it makes more sense. I will firstly present the key findings overall, as a starting point for a more in-depth analysis. I will also examine some of the discourses that emerge. (Key – for quotations *NAPH* = Nurses and allied health professionals, *Admin* = Administrative and support staff, *I* = Interviewer, *M*=Male, *F*= Female).

1. Employee engagement comments and themes

Root Code title	Child Code title (if applicable)	Code Descriptor	Reason for code	Number of excerpts
Employee Engagement comments		General comments on EE	Participants in both focus groups and interviews were asked to comment on the concept of EE.	54
	Familiar with the term EE	Are participants familiar with the term EE, and other terms they use. Comments on measurements of engagement	I was interested to find out what people knew about the concept of EE and identifying similarities and differences.	14
	Barriers to EE	Comments on what gets in the way of EE	Understanding the barriers and drivers to EE were a goal of the research	48
	Drivers of Engagement	Comments on things that facilitate EE		44
Locus of Engagement	General comments	What people say about the locus of engagement	An emergent theme from the focus group discussions which also appears in the literature	10
	Engaged with co-workers/team	Locus of engagement is with co-workers or the team	This was mentioned a lot in the discussions	15
	Engaged with the organization	Locus of engagement is NHS Lothian	EE literature suggests that EE is with the organization goals.	11
	Engaged with the patients	Locus of engagement is patient care	An emergent theme	28

Table 14. Coding frame- focus groups 1

Employee engagement comments and familiarity with the term

In terms of general comments on EE, generally respondents were not familiar with the actual term ‘employee engagement.’ However, as one pointed out, they were familiar with some of the underlying ideas and principles. Most agreed that it was a relevant concept in the health care sector.

NAPH

F1 Yeah I, I mean it's obviously really important isn't it, in any job that you are in that you are involved and committed. I guess the term is not one that we are used to.

F2 They don't use those words.

So although staff overall did not use the term ‘employee engagement’, the description I offered formed the basis of the subsequent discussion. Whilst staff readily adopted the term EE in the context of the focus group, it formed a useful basis for the subsequent critique.

There was a recognition that experiences differed, and that individuals would have different attitudes with respect to EE, and different criteria.

NAPH

F. The extra mile for one person might be someone else's norm

Engagement was seen as a two-way pact between staff and the organization:

NAHP

F1 And I, I also think there's something that maybe goes back to management and how the place is organised.....That if you, if you regularly are going the extra mile....if when you need the organization to be flexible with you, they can be flexible with you.....then, you know, you are more likely to get that (EE).

I And do you think that happens then?

F1 Well it does where I work.

F2 Yeah you get thanks for it obviously if you go the extra mile.

I Right you do?

F2 Yeah.

F1 They appreciate that and...

I You feel yeah, so it's a sort of give and take.

F1 Mhmm

It was suggested that not all staff are engaged.

F1. I think there's quite a, not a substantial, em, group of people who have no interest in learning or being engaged as an employee.

F2 Hmmm.

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F1 And just eh, em, come in and potter about and go home. But the sort of vast majority of staff are committed and go the extra mile and I personally find it quite hard when people do relatively little. And it's getting, about getting these people engaged.

F. Some folk just don't want to be engaged, that's it.

However there was a strong sense of a workforce working at the edge. Cutbacks and the moratorium on recruitment were coupled with pressures to meet targets and 'do more with less'. It was felt that more and more was being expected of staff and that this was having a detrimental effect on morale and on attitudes to work. Some staff felt that they were in danger of burnout. Staff frequently commented on working longer hours, a faster pace of work, pressure to meet targets, coupled with a feeling of not being appreciated or their efforts being recognized. The effect was to impact upon their experience of engagement, leading to resentment and lack of motivation. The notion of engagement including 'going the extra mile' sparked a lot of comments:

It's not that extra any more.

The extra mile is more than a mile now.

They are expecting so much more than that extra mile.

We're actually probably at our peak anyway.

I'm becoming less tolerant to the extra mile because of the, what we are having to do as daily bread and butter

We're asked to do a lot every day.

Now there's no slack in the system just more pressure.

Goodwill is being eroded slowly

This sense of being under pressure formed a significant backdrop to the whole focus group discussions, and one I will explore further at a later point in this chapter.

Drivers for and barriers to engagement

I asked an open question, asking what people saw as the drivers for and barriers to engagement within NHS Lothian, things that facilitate engagement or get in the way. I also showed participants the list of suggested drivers of engagement (see methodology chapter for list of questions). In terms of drivers, answers focused on the nature of the work, and what the organization could or could not do to facilitate engagement.

Drivers for engagement

As this formed a significant theme in the discussions, general points are explained in this section, and later sections explore significant points in more detail. Staff commented on

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different experiences in different posts, and suggested that job satisfaction impacted upon engagement. Being valued and rewarded contributed to engagement, as did seeing how your work fitted into the bigger picture. Learning and development initiatives such as the PDP were seen as good for engagement. These comments seem to accord with the literature on EE.

Patient care was seen as a motivator for job satisfaction, again for admin/support staff as well as clinical staff, as was working within the NHS.

Admin.

F. Cause none of us would have, let's be honest, none of us would have these jobs if it wasn't for the patients.

Having a good team to work with, support from the organization such as good communication, and flexible, supportive management was mentioned. Fairness was seen as important – if the organization supports you then you will feel committed to it. Having clear objectives, good feedback, recognition, and being able to see how your work contributed to the 'bigger picture' were all seen as important. Some stressed that these were ideals, but did not always happen in practice.

NAPH.

F. What happens in our, in our department is, I guess as (x specialism) as well we have a really good supervision structure and it's, it's very clearly adhered to.

I Hmmm.

F So I think we do get time to sound off or talk about worries and that takes up, I was surprised as well, and it takes up a lot of my time (as a manager). But it's really valuable and it does make a real difference.

Admin.

F But I think it's all about communication.

NAPH

M And it's about recognising people's effort yeah. And that's what makes people think that you value them.

Colleagues were frequently cited as a driver of engagement, both as a provider of support and staff feeling a sense of commitment to the team.

One person had a discussion with other members of her team to get their views prior to attending the focus group:

NAPH

F. I suppose the biggest thing that came out of our little discussion this morning was having good colleagues, supportive, positive people round you and people who were, just signed up to the ethos and belief locally of what, what our little mini project is all about.

Learning and development opportunities were also mentioned as drivers for engagement, as was good quality training, and opportunities to put learning into practice.

Admin.

F. The job I'm in right now, I mean I think it's excellent. Em, when we, when I had my PDPR (sic), em you know, the person who does that with me is just tremendous... she will bend over backwards to make sure that, you know, I have every opportunity to either do any course if there's something that I think I want to, to learn.

A predominant discourse was that of staffs' professional commitment. The perception of staff is that a small number of staff may not share this, but the majority is committed to their work. This was a recurring discourse in the focus group discussions.

NAPH

F. But I mean we are lucky in that the NHS is full of people who are very, em, committed to what they do.

NAPH.

F. And I think staff, that we have that work in the NHS are, are very committed just, everybody's said. Em, I think they want to do a good job and I think they want to, eh, make sure that the patients are getting the best that they should be getting.

This seems in accord with the notion of shared organizational commitments, and complementary professional narratives between staff and organization. But the context of the comments is important. The suggestion that '*I mean we are lucky in that the NHS is full of people who are very committed*' is presented within a discussion that is critical of the way that the organization is managed. The suggestion is that the staff could also be committed *despite* the way that the organization is managed. Thus the same statement has evidence of both shared and contradictory professional narratives.

Barriers to engagement

In terms of barriers to engagement, a particular striking feature of the focus groups was the strength of feeling about the problems and difficulties they were experiencing in their work. Staff commented on low morale, firefighting, feeling demotivated, not feeling empowered, and goodwill being eroded. They expressed frustration, anger, feeling stressed and being under more and more pressure, and some had a feeling of job insecurity. There was a sense of many in the organization feeling unsupported and undervalued, and pushed to the limit.

NAPH

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F I think I'm becoming less tolerant to the extra mile because of the, what we are having to do as daily bread and butter is extra isn't it [laughs] Well I think we're, we're asked to do a lot every day.

I ...yeah right.

F Every single day.

NAPH. (Community staff)

F1. I think they are all feeling the brunt of that at the moment. Em, they are not employing anybody to cover maternity leave or, you know, and we are certainly feeling in the community with more and more people coming out into the community. And it's, it's tough out there but I'm sure it is everywhere so.

F2 It's everywhere I'm sure.

F1 So it doesn't do much for staff morale at all.

NAPH,

F. a lot of us don't particularly feel empowered.

I Right.

F Because of the lack of resources and so on and so forth. Lacking of, staffing's a real problem for us at the moment, you know.

I Right.

F If somebody leaves are they going to be replaced, no.

Admin.

F1 Well it was good up until about two years ago. And now that's us, it just seems to have gone downhill.

I Really.

F1 You just don't seem to have the same enthusiasm. And as you say, we are not allowed to go on courses.

I Right.

F1 We don't have time, staff, staff to cover us. When we do go on them.

F2 And we're getting a lot of work taken from us.

F1 Yeah.

F2 Has gone to the nursing staff.

Other barriers included negative team members having an impact on the rest. Some general comments were that people could not be forced to be engaged, and efforts to do so would have the opposite effect.

NAPH.

F. Just, em, for a while there that was hard just for us just because we had one member in the team who was negative and, em, it wasn't helpful at all. Not helpful at all.

One person commented on a marked difference between her work in a ward and her current role on a secondment. She felt that the recognition and feedback she experienced in her current role contributed to engagement, unlike her experience on the ward:

F. Yeah, I'm happy to go the extra mile at work when required I would say is very true of the role I'm in at the moment. Em, but I know that when I go back to ward (...) then I won't be happy going the extra mile [laughs]. Regardless, patient care obviously but sort of outwith that then no...., as soon as half past eight comes I'm, my jacket on and ready to go home.

Locus of engagement

Staff noted that engagement could be determined by or directed towards a particular group of people or parts of the organization, which I have interpreted as ‘locus of engagement’. Staff felt engaged by the team, work group, ward, or sometimes their hospital. A supportive line manager could stimulate engagement. People felt loyalty to their profession, or to the idea of the NHS, rather than the organization NHS Lothian. NHS Lothian seemed too large to identify with. An overriding locus of engagement was to patients.

NAHP

F1. And it is about the local connection and how we're valued as workers by those around us.

F2 Mhmm.

F1 I, the team and the line management.

People referred to NHS Lothian as ‘a juggernaut’, ‘you feel just a number’, ‘its just too big to identify with’.

Admin.

I Do you think, um, just one final question really on that, I mean do you think staff identify with the organization or perhaps more with the team or department?

F1 It's first of all really with the team.

F2 I think it's, I think yeah, I think it's both. I think it's, it's the team, it's how they feel that they fit into the team. But the other side of the coin is it doesn't matter what they are doing, what I'm doing, what the CEO's doing.

F1 Yep.

F2 At the end of the day it's all for the patient.

F1 Yeah.

I Right yeah. And that's something people feel very conscious of?

F2 And that is something people are very very conscious of.

The varying loci of engagement is summarised in the comment from a focus group:

NAHP.

F I just think that, you know, phrases like 'commitment to their board' (in the NHS staff survey), it's like, you know, I don't know of anybody else but I don't feel I, I'm NHS Lothian, you know.

I Hmmm.

F1 I don't identify myself in that manner at all.

I No.

F1 Your commitment is to your patients...

F2 Your patients.

F1 ...and your colleagues...

The following sections explore locus of engagement in more detail.

Engaged with co-workers and the team

Being engaged with co-workers or the team was mentioned a lot. Staff said they felt a bond with colleagues, a sense of loyalty, and that they would stay on late at work to help them. The hard work of team members was appreciated, and team members had a shared sense of humour.

F You don't want to be seen to let your colleagues down.

F. Definitely at team level rather than even at managerial level.

NAHP.

F1 There's commitment to your colleagues

I Yeah right.

F1 That's why you come in because you, it affects your colleagues, if you don't attend then it affects other people you are working with. And it actually, I would say the organization is staying together at the moment because colleagues are faithful to each other.

I Mmhmm.

F1 And have a degree of loyalty. Not to the organization but to the department and their colleagues.

Loyalty to colleagues can also be considered as a discourse. On one level this seems to accord with 'The Lothian Way' principles of partnership. But there is evidence of a disconnect between the loyalty to colleagues and to the organization. We see a tension, '*the hierarchy*' and '*the organization*' are seen as separate from '*the department*' and '*colleagues*'.

Engaged with NHS Lothian and NHS

With respect to the issue of engagement with NHS Lothian, people generally felt a loyalty to their profession rather than the organization. It was noted that staff might choose their profession, but there was little choice of which organization to work in if they wanted to practice. There was however a sense of commitment to the wider NHS. Some people felt commitment to their managers rather than the wider organization. There was a lack of understanding of some wider organizational objectives, although certain objectives such as the four-hour targets were more widely recognised.

F. Is NHS Lothian a good place to work? Well no. Is the ward that you work in a good place to work? Maybe

F. Personally I think politically I still believe in the ideals of the NHS.

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It was recognised that the organization sought to communicate widely, but staff felt it was difficult to relate to all that was going on beyond their particular specialism or unit. There was some greater understanding of the organizational objectives since the recent talk by the Chief Executive, which had been videoed and made available to staff throughout the organization.

M I mean it's nice to hear about stuff happening elsewhere but you're maybe more interested and more inclined to have a good flick through it if it was more about your area or, you know, more specific. Cause if I hear stuff about the Western or the Royal Infirmary I tend, you know, I'll have a glance at it and see if there's anything about mental health. If no, I tend to put it tae the back burner.

Some said they felt a tension between their loyalty to the organization and to patients. Others felt that the cutbacks were impacting on their sense of loyalty to the organization. However some who were in management roles felt more of a sense of commitment to the organization.

NAPH

F1 It's not good, really.

F1 With financial constraints, with job freeze and wage freeze.

I Yeah.

F1 It's very difficult to, em, engage with them really.

The commitment to the aims of the NHS can be considered as a discourse

Admin

F1. Em, but because everybody agrees with the idea of it as well, the NHS, we would hate to see that go.

F2 Yes yeah.

F1 That must be a driver for that extra mile.

'Everybody agrees' would again suggest that the aims of the organization and the principles of the NHS are in accord. But the NHS is seen as an abstract construct rather than embodied in the particular organization. The organization is not the NHS. It is possible to criticize the organization whilst being in favour of the NHS.

Engagement with patient care

A significant theme in the focus group discussions concerned engagement with patients.

There was a shared professional narrative about patient care, from both clinical and administrative/support staff. The organization exists to provide patient care, and all the work is for the patients. Staff said they would go the extra mile to help patients, and obtained satisfaction from knowing when a good job had been done for the patients. There was mention of the vulnerability of the patients, and a sense of the significance of the work.

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Patients provided appreciation and recognition for the hard work of staff, which was not particularly forthcoming from the organization. Admin/support staff noted that they feel engaged with patients as much as clinical staff.

NAHP.

F1 I would do anything for the care of patients.

F2 Well you want to be cared for the way, you want to care for the patients the way you want to be cared for.

NAPH.

F That makes you do the extra mile. Not actually working for the organization. It's the people at the end of the line waiting for those results.

NAHP.

F. I mean we know ourselves if we are satisfied with the service we give our patients, that's certainly us being engaged and being motivated. ...We do what we think and we give our patients a very personal service and we are very patient centred.

Again administrative and support staff felt engaged with patients.

Admin.

F2 At the end of the day it's all for the patient.

F1 Yeah.

I Right yeah. And that's something people feel very conscious of?

F2 And that is something people are very very conscious of.

Admin.

F Well the patient, that's where the job satisfaction comes in.

One can also consider the centrality of patients as a discourse. The *raison d'être* of the staff is caring for patients. Commitment to patient care can be viewed as central to staffs' identities as professionals. This applied to administrative as well as clinical staff.

Admin.

F1 ...you are seeing them all day every day. And, I mean, in places like outpatient departments, accident and emergency departments, ward based staff, it is all...for the patient.

I For the patient rather than the organization?

F1 Yeah definitely.

F2 Why is the organization there? Because of these patients.

One might conclude that the above comments are in accord with the organization discourse of service excellence. But in some respects the staff's emphasis on '*its all for the patient*' is presented in opposition to the organization, '*the other side of the coin*'. Staff are there '*for the patient*' rather than '*for the organization*'.

2. NHS Lothian as a place to work

A further strand to emerge from the focus groups concerned observations about working within NHS Lothian. Whilst some have already been mentioned with respect to employee engagement in general and the locus of engagement, this section explores in more depth how staff feel about the organization, its management, the current climate, targets, workload, and how change is managed.

Root Code title	Child Code title (if applicable)	Code Descriptor	Reason for code	Number of excerpts
NHS Lothian		Views on NHS Lothian	It was interesting to note views on NHS Lothian as it is the employing organization.	35
The NHS		Comments on the NHS, history etc.	A range of views were expressed on the wider context of the NHS	8
The current climate	Cuts etc	Also includes the policy framework	An emergent theme	69
	Targets.	Working to targets, often set by Government, e.g. waiting times. An emergent theme.		43
	Workload, pressure	Comments on workload and pressure	An emergent theme	51
Organizational change		Comments on organizational change	An emergent theme	7
	Change management	Comments on how change is managed	An emergent theme	26
Comments on management		Comments on management and managers	An emergent theme and also one which features in the literature of EE	54
	Not being listened to		An emergent themes	18
	Criticisms of management	Comments critical of management and managers	An emergent theme	55
	Bullying		An emergent theme	8
	Teams	Comments on teams, multidisciplinary working etc.	An emergent theme	14

Table 15. Coding frame- focus groups 2

NHS Lothian

Regarding NHS Lothian, most staff are aware of the various targets, and recognize the constraints and impositions on the organization that evolve from government level. There was more awareness of corporate goals since a recent presentation by the CEO of the organization, and a sense of shared issues across divisions

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NAPH

F. I think since we've had the big presentation, the (CEO) presentation, I think it's alerted a lot more people to actually what the visions and goals are. Cause I don't think I really knew before that.

However there was considerable frustration expressed about the organization. As mentioned, many felt it was just too big to identify with, and there was a lot of hierarchy and bureaucracy.

NAHP.

F. But I feel so totally out of touch with the organization.

F. The board is some faceless thing.

Admin

F empowerment is not something that is always, it's sometimes quite frustrating, em, because you can't, because of the size of the organization.

I Right.

F I think it's the hugeness of it.

F Yes mmhmm.

I Hmmm.

F Big lumbering machine. Um, everything takes a long time and support staff, .. are at the bottom of that really.....

F There's a lot of hierarchy within the NHS.

I Right yes.

F And I think that's where some of the difficulties lie.

I Right.

F And communicating is a problem within such a huge organization

NAPH

M I think sometimes different, different initiatives within the organization are actually not aligned. And so you are expected to be doing x, y, z without any cognisance of the fact that you can't do a, b, c because of having to do x, y, z. And I agree that it's so hierarchical, you know, there's no, um, choice really involved in it. You just have to do it.

NAPH

F But I think it, I think there are some divisions. They talk about ...the Royal Infirmary is called the hub and the Western takes the mickey out of the Royal Infirmary. And the Royal dismisses the Western because the Western is a smaller hospital And that's all done in a bit of a jokey way but there's underlying tension.

Some staff felt that there was more job security working in the NHS than in other sectors, and that the organization looked after staff well and had family friendly policies.

Admin

F You know, I think as an organization we are, we look after our staff quite well.

NAPH

F1 I think I'm quite, just quite happy to have a job the now as well actually.

I Yeah.

F1 Quite grateful that I work for NHS. At least we are not gonna, touch wood, get laid off.

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NAHP.

F1 a very obvious, em, barrier in our work where, it's like an upstairs downstairs.

I Right.

F1 And I think that in itself actually creates a huge barrier.

I Hmmm.

F1 So I think that will, I don't know if that will ever really change to be honest.

F2 What, the people upstairs are better than the people downstairs?

F1 Stay upstairs, and people downstairs stay downstairs [all laugh]. And they don't mix and they don't meet unless they are at a meeting.

Admin.

F2 In fact I thought there was a message from the executive directors saying they will not be making redundancies.

F1 But we are not frontline staff, we're backline staff.

F2 Oh right.

F1 We are not frontline staff. We're backline staff. We are not important. We are back, we have been told we are not important, we are backline staff.

I Is that something you feel is a message or something.

F2 No that was the message was given. You are not frontline, frontline staff are nursing.

Administration is backline staff that's what, back door it was called wasn't it, back door staff. And I felt that term was derogatory to start with because it's bit like you're, you are serving wenches that are allowed to go in the back door. I mean from the eighteenth century, you know. You can come in the back door but don't go in the front door.

There is a vivid image of how administrative staff suggest they are perceived, which seems in sharp contrast to the discourse of 'The Lothian Way' 'respecting people as individuals and treating them with courtesy and dignity'. Somewhere along the line the notion of *frontline* and *backline* staff has been communicated. This staff member has '*been told we are not important, we are backline staff*'. She was quite emphatic, and the '*derogatory*' term stimulated an image of '*serving wenches*' '*from the eighteenth century*'.

Views on the NHS

Staff felt a strong commitment to the NHS.

Admin

F I mean I, the idea, the NHS itself, I think everyone is really behind the system for the NHS. You wouldn't want to see no NHS.

Admin.

F2 And I also feel that it takes a certain breed of people.

F1 Who won't do that?

F2 To work for the NHS [laughs].

I Yeah in all types of jobs yeah.

F2 Yeah.

F1 Yeah.

F2 Definitely. I think they've got to be...quite committed.

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But the climate of cutbacks meant that some staff felt insecure and there was frustration by the political visibility of the NHS. Not all staff felt protected by the promise of no redundancies.

NAPH

F. I think the NHS, certainly at the moment it's generally such a negative place to be in anyway. You don't ever, or you, I certainly don't or very often hear about positive things that's happening. And certainly with the restructuring of staff and whatnot, the cutbacks, em, it's not a nice place to be just now. concerns about whether people's jobs are safe.

Administrative staff in particular felt vulnerable, as they were not protected by the Scottish Government promise of no redundancies in the NHS, assuming this only applied to clinical staff.

Admin.

F1 , it's a shame really because there's lots of good people in the organization. But they are not being allowed to, em...

F2 To flower.

F1 ...to flower.

I I wonder why that is happening then?

F1 Well you've got the fear I think at the moment....People are terrified of losing their jobs.....

The current climate

There was a recognition of the wider policy context of financial constraint, and there were a lot of comments on the impact of this, such as the ban on recruitment, wage freezes and financial limitations, to 'do more with less'. The political control of the NHS also formed a backdrop, with recognition of the accountability to government to meet imposed targets. All this was coupled with the need to manage patient expectations.

Admin.

F. And at the moment finance is the massive, massive driver at the moment.... money has to be saved

There were some positive comments, concerning elimination of waste and creative ideas. But overall the situation was causing a lot of strain on staff, having to manage with fewer staff, opportunities for promotion curtailed, lack of cover to do training, feeling overwhelmed by paperwork, and a constant climate of change and feeling unsettled by job changes.

NAPH

F. But we haven't been able to recruit to the posts that were replacing them which has left a few people running round in circles

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F1. A lot of changes in the last two years.

F2. The goodwill in the NHS is running out.

NAPH.

F. We are operating at unsafe levels, especially nursing, unsafe levels. You know, sort of procedures and stuff to be cancelled or delayed because they can't, nursing staff can't escort patients to procedures and to this and that and it's just a continual build up of problems because the staffing levels are so dangerous.

Staff also commented on the impact of the situation on their behaviour. Staff were afraid to challenge or stand up in case they were singled out.

Admin

F. I don't want to be the one with my head above the parapet.

NAHP.

F. So you've got this, em, kind of tension between your loyalty to the organization but, but also to your patients. I, I agree with that, I think a lot of clinicians feel that very strongly. Because I think everybody that works in the NHS is loyal to the NHS. But if you see patients being disadvantaged by service cuts then it's quite tough

Targets

As mentioned, staff were all aware of the targets, and there was some sense of the organization working together to address targets. There was recognition that many targets were government imposed and that the Board was required to respond. However there were also concerns over the pressures which seeking to meet targets placed on staff, including managers, and how meeting targets seemed to take priority over other aims.

NAPH.

F. Scanners were not built to scan as many people as that. And they just blow up every now and again. And we fall further and further behind because they're being so overheated and overused.

There was some criticism of how the organization was addressing targets, and communication around targets. Targets seemed to generate a lot of paperwork and administration.

NAPH.

F. I think it's just, I don't know, just bureaucracy gone mad.

NAPH.

F1 But you see people being inappropriately,referred to a service just to get them off the waiting list.

F2 Mhmm.

F1 They are deemed to be inappropriate so they end up going back to their GP, having to wait. So some poor person who genuinely needs a service has been bandied about so as to avoid sitting on a waiting list.

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There is understanding of the constraints, but resentment of the way that targets are managed:

NAPH.

F1 You can kind of understand, I suppose, from the community mental health point of view. They are trying to make us all work much more effectively. And we get emails saying 'so and so is breached, breach breach breach the waiting list'.

F2 Trip trip trip [all laugh].

Admin.

F But higher up it's, you know, when you are talking about targets, it doesn't matter if you've done 99.999% of it right. You've done that odd one little thing that's not right. And the rest is completely forgotten. And I'm not looking at that necessarily from me.

Targets are experienced as a disciplinary technology, you 'just get your head down' and do what you are told.

Targets can be seen as NPM discourses to construct new identities for public sector workers, for example through the disciplines of performance management and quality assurance. These can be regarded as new regulatory regimes. The targets discourse acts to shape social practices. Staff are all aware of the targets and there is reluctant compliance. But they complain about pressures and problems in this compliance. There is resentment – they don't 'own' the targets. But they do understand the wider political context. Nevertheless, they still complain about the managers.

Workload and pressure

This has already emerged as a key theme in the focus group responses. But it was such a recurring theme that it merits further emphasis in the reporting of findings. Staff talked about exhaustion, burnout, rushing through work, being on the edge, feeling overwhelmed, having more and more expected of them. There was quite a lot of ironic laughter and humour expressed.

Example comments

-Like there are a finite number of hours and I'm a finite person.

-It's exhausting

-It's not that we are sitting down drinking cups of coffee and filing your nails, you know.

- But there's not much more to give, I think.

NAPH.

F.1 The job is so wide isn't it. The job description is so wide, you can't possibly do it all, isn't it really. You can just maybe do part of it. At the moment anyway.

F2 Hmmm.

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F1 That's how it feels. You feel overwhelmed.

Job satisfaction was eroded, staff were having to take on extra administrative tasks, and work uncompensated overtime.

NAHP

M I was just going to say that because there's no slack in the system...

I Aha.

M ...whatsoever...

F Mhmm yeah.

M ...you can't return the goodwill to your staff who have stayed till seven o'clock.

A member of staff working in mental health nursing notes the following, suggesting that he was too busy with routine tasks to do what he considered the important therapeutic aspects of his role:

NAPH

M You know, that's what makes work interesting. I mean I work thirteen hour shifts and I had the slowest weekend of my year and half here last weekend. And it was dreadful, you know, because it was just thirteen hours to endure. Whereas if you've got stuff to be getting on with, time passes. You come out, going 'phew, knackered' but at least, you know, it's over, you know what I mean. So it's not about, you know, eh, the busy-ness side of things, you know. Being busy is okay. It's being stretched so that you can't be properly busy as it were [laughs].

Managers were also seen to be under intense pressure, and this meant they were less available and sometimes it impacted upon their management style, as will be noted later.

The following quote is from a focus group participant with training responsibility:

NAPH

I So there's a big sense of commitment but you are feeling quite on the edge, you used that term

M Just having the privilege of going round to five or six different units.

I Yeah.

M Where I have candidates working and just see people right at the very edge of what they can deliver.

F Mhmm.

M All the time. And yes the commitment to the patient is still there but are they gonna stay behind and get through it anyway or are they gonna stay behind and do more admin or are they gonna stay behind and answer fifty emails. Possibly not now. Whereas in years gone by you would see people still two hours later doing the off duty, you know, or answering mail two hours later.

I Hmmm.

M Or making sure the stocking up was correct. But of course if the patient's, you know, in bother people still stay.

This is a discourse of 'there's not much more to give'. However, it is perceived that the organization does not seem to recognize or to care about this situation:

NAHP.

F. *They always want that bit more from you....you've never done enough.*

There is also suggestion of a 'self-regulation' discourse. 'Disciplinary technologies' 'seek to colonise worker subjectivities, such that they participate in their own subjugation' (Thomas and Davies 2005:686). In the following extracts we see evidence of this. Staff complain about the expectation to 'go the extra mile', but they do it anyway, but reluctantly, and without appreciation. It is recognised that things were different '*before*', whereas now it is '*expected*' that you '*do that extra stuff*', it's now '*the norm*'.

NAPH.

F. *I think, like you say the extra mile before was if you were interested in, you know, if you wanted to get involved in a development, you know, you were really supported and encouraged. Whereas now it's kind of expected that that's part of your job. It's, it's not something that you get the gratitude for and appreciation now. It's just expected that you do work, that you'll do that extra stuff.*

NAHP

F. *Or is it because people are, if you look at it quite negatively and say, you know, people only go the extra mile in their work because they know they have to, it's a regular thing, you know.....Yeah they just, they do it anyway, they do it every day in their working environment anyway..... And they are working, understaffed....Or staying on a little bit late because you are continuously working understaffed and that's what you are just getting used to and that's the norm, I dunno. They could say that negatively..... And of course the extra mile for one person might be someone else's norm.....And vice versa.....Someone might be saying well they wouldn't go the extra mile but actually they do on a regular basis.....They just see it as the norm.*

This sense of 'you've got to get on with it' is seen in the context of commitment to patient care. But there is 'a vicious circle' which is experienced as exploitative.

NAHP

F1. *That's expected of you though to go that extra bit. You know, it doesn't matter how, how much. You've got to get through it, you've got to get to the goal posts.*

F2 *And you've just got to do it for the sake of the patients.*

F1 *Yeah that's right, you cannae, you know, you cannae say 'right it's half four, time I was out of here, I'm away'. You just, and if it's half past six. And then it just becomes 'oh well you stayed till half six yesterday, why can you not stay today'.*

F2 *Mhmm.*

F1 *And you stay till seven o'clock the next day. What, you know, 'why can you not do that today'.*

F2 *And then they can't pay you and you can't take your TOIL.*

F1 *Oh and you can't get the time back because there's no staff.*

F2 *And you can't get the time back.*

F3 *Yeah yeah.*

F1 *You know, so it's a vicious circle.*

From the perspective of EE, the following extract indicates how staff will 'go the extra mile' because of their '*professional standards and commitment to patients.*' But it is felt that this is

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taken for granted, *'it would fall apart at the seams if we just stuck to the letters of our contracts'*.

NAPH.

F. *And this one is quite high, 'I, happy to go the extra mile at work when required' (from the NHS Staff Survey).*

F *Yes, yes people are because they have to.*

F *Yes.*

F *You know, because we've all got professional standards and commitment to our patients. And we do it because it's all...*

F *We care.*

F *...we care and because it's been.....*

F *...we're happy to do it, we're professionals. But it's been almost foisted upon us.*

F *Mhmm.*

M *It's almost taken for granted.*

F *It's taken for granted.*

I *Is it?*

F *Yeah, NHS Lothian, NHS Scotland relies on the goodwill of it's staff. And it wouldn't function without it.*

M *I said that didn't I.*

F *I would totally agree with that.*

F *It would fall apart at the seams if we just stuck to the letters of our contracts.*

Another discussion referred to the expectation to 'go the extra mile'.

NAHP

F. *I think I'm becoming less tolerant to the extra mile because of the, what we are having to do as daily bread and butter is extra isn't it [laughs].*

F *ironic isn't it.*

I *Really?*

F *And I think they are factoring in charity from us.....*

F *And the extra mile now is, it's, is really, you know, cause we have increasing demands. And you don't know what they are until you are in and doing them. And it's not that I'm cynical or hate my job but I do think they, em, they need to realise that these are tough days and what they are asking to do just in terms of bread and butter is tough already.*

I *Right.*

F *And the extra mile isn't there because we're all having to put more effort in anyway.*

One focus group participant described the impact of staff 'feeling flogged'.

NAPH

F1. *It's true but I see more people now who are on the cusp of saying 'oh blow it, I've done as much as I can, I'm going'. Just on that cusp. Whereas you wouldn't see that previously. And that's only because they've been flogged every single day.*

F2 *Hmmm.*

F1 *Basically you are flogged.*

Another commented on how the constant pressure was demotivating.

NAPH

F *It's the next, always the next bit. And you, after a while you get a bit de-motivated because you think 'well I've done it, I've done my bit, I've put all my energy into it and then nothing, it all just kind off falls apart'. And I think that everyone who works with the NHS is very committed to it. And I*

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don't really know that our, the amount of energy that people put actually into their professional practice is actually recognised.

Organizational change and change management

One question in the NHS Scotland staff survey asked if the organization managed change well. It was agreed this happened in some cases, such as the move to the new HQ, but there were also criticisms. It was felt that there were too many changes, and that there was often poor communication around changes. However it was also suggested that there would be some people who did not like change.

NAPH.

F ...in the time I've worked for NHS Lothian it went from this little Trust to a big one and then back to a small one. And it's like...

I Reorganization.

F ...reorganization, I've only worked for twelve years in the organization. It's just, I mean it's gone full circle in some senses.

Consultation was seen as sometimes tokenistic. The implementation of Agenda for Change came in for some criticism.

NAPH.

F1. I think there are times when changes are done too quickly without enough consultation.

I Right.

F1 And there are other times where you feel like you are bogged down in consultation when you could have done something like a year ago or something, you know.

F2 Hmmm they haven't got that quite right

F1 And that may be something that depends on the personalities that are involved in making the change.

F2 Mhmm.

NPM argues that old public sector bureaucracies must be replaced by 'efficient' models of management based on private sector principles, for example through internal markets. Some of the staff comment on hierarchy and bureaucracy:

Admin

F There's a lot of hierarchy within the NHS.

I Right yes.

F And I think that's where some of the difficulties lie.

I Right.

F And communicating is a problem within such a huge organization.

Admin

F Like you I came from private sector. This is my first experience of public sector.

I Oh okay yeah.

F And I'm sad to say it lives up to its reputation [laughs].

I Really yeah?

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F As far as like for the bureaucracy and the unwillingness to change. 'We've done this this way and we will continue to do it as well' 'but can't even try it', 'no'.

I So you see quite a marked difference?

F Oh gosh yeah.

But as Davies and Nutley (2000) comment, contradictory organizational effects are created by the policy shifts. Somewhat paradoxically, systems of upward accountability, and weakening of professional authority have the effect of making the NHS now more bureaucratized.

NAPH.

F I think it's just, I don't know, just bureaucracy gone mad. I think you're right, I think we fill in a lot of forms, em, sometimes just to keep the NHS happy in case they get sued or whatever. And they are so scared of what's gonna come next.

Some staff hanker after older way of organizing. Changes have caused uncertainty:

Admin.

F I think, I think the commitment to organization at the moment, I mean when we first joined there was a definite structure to the organization, definite job values, job satisfaction, you had a clear role. And I don't know about anybody else but in the last year, year and half since Agenda for Change, everything has changed. The job satisfaction has fallen a great deal.

I Really hmmm.

Management and managers

A number of comments were made concerning staff experience of being managed. There were mixed experiences; it was felt that the majority of managers were good but that some were not supportive - *"we're a very large employer and a microcosm of society"*. Good managers were supportive and treated staff with dignity *"there isn't a blame culture"*. Poor managers did not listen, and there was poor communication, and a 'them and us' feeling. Management initiatives such as sickness absence targets caused some concerns. Overall there was a lot of paperwork and documentation required. Some of the participants were themselves clinical managers or managers of administrative/support teams, and their comments reflected this dimension.

NAHP

F. The administration or paper side of things has, has gone crazy though. It's colossal the amount of documentation that you have to do.

NAHP.

F. I recognise with our manager, I think she's excellent I think so much gets thrown on her and they've taken away a level of management. I just, I don't know how we do it. (she) really listens to people and tries to support them even in this climate. Getting tougher for her but, eh, it really makes a difference for me.

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Staff recognized that managers were under a lot of pressure, and increased workloads meant they were less available to their teams. In some cases this had resulted in a change in management style, which had become more autocratic.

NAHP.

F1 I feel I've really good managers, local managers and approachable managers that occasionally you get the stress that they are under some, to achieve some kind of target.

I Hmm.

F1 And then it, you know, the style maybe changes a bit and it becomes more bullish.

F2 Mhmm.

F1 And that's a complete turnoff

One member of staff commented on how her manager's stress impacted upon her:

Admin

F Our, em, portfolios have all been restructured because we've lost our director. And we've lost certain key members of staff.....But we aren't allowed to drop anything. We still have all the same targets.

I Right.

F We still have the Scottish Government on our backs. Everything still has to done and yet here's another pile that also needs to be done. And I know certainly, I work for two people in different teams. And one of them is absolutely, I mean she works fifteen hours a day her Blackberry is with her constantly. She's never off. Em, the other one's managed a better balance but...and the problem is then that forces me, every time I go in I've already got twenty five emails before I've even, you know, basically switched on my computer.

I Yeah.

F And if I was still there after five, which is fairly usual, I'm still getting emails from her. And it does feel, I'm struggling to feel motivated cause I feel it doesn't matter what I do or how much I try to do there's always another pile of stuff that doesn't get done. And I think that, that is difficult. And that is kind of the budget cuts as well.

One member of staff contrasted her experience of working in the private sector with the current situation.

Admin.

Fwhen you come from the private sector which is, well I, maybe I've been lucky but I've worked for small companies and large companies. And they've always been fairly open door.

I Mhmm.

F Quite relaxed and, you know, you have to show respect to the senior people.

I Yeah.

F But you don't have to bow and scrape whereas here I, I felt a little bit more uncomfortable and a little bit more intimidated and a little bit less likely to express my opinion.

The NPM discourse as espoused by the CEO is described by one member of staff, speaking about the recent video of a talk by the CEO:

NAPH.

F So it was very difficult to gauge what, apart from what it was saying. So it went on about visions and commitments and how he wants to be one of the top twenty five NHS, sort of like in the world etc and NHS Lothian to be the best in Scotland. Which is fabulous but I would have to be honest it would have to be really clearly defined how we'd achieve that. And given the current financial climate the only impression we got was really kind of you have to be more efficient cause

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we're going to get less and less staff but you've still got to do more and more work. So, em, to be entirely honest, by the end of it we weren't particularly all jumping up and down with joy.

Here the member of staff seems to see through the rhetoric and sees little of substance beyond this, other than a demand for 'more for less'. Other focus group respondents describe their thoughts and experiences:

F2 Yeah you are right aha. You're just a number.

I You feel just a number.

F2 Sometimes.

I In the organization.

M It's always like a brand. You know, it's NHS Trust, NHS healthcare and then another couple of years it just changes it's name. You know, who are we?

F1 Yeah.

I That's interesting yeah.

F1 The more remote the level is...

I Right.

F1 ...then the less we feel empowered and committed to it. And that's my view but...

F2 No I agree.

New management practices draw on private sector perspectives, such as branding and marketing. But paradoxically this staff member suggests that rather than cementing a sense of identity, branding or constant re-branding just causes confusion – 'who are we?' Staff now feel less empowered and committed, and less identification with the organization 'you're just a number'.

Another describes the contradictory imperatives of shifting the balance of care under reduced resources:

NAPH.

M And it's interesting in the community as well. I mean the NHS Scotland quality strategy, I mean shifting the balance of care. It's all about doing less in hospital and more in the community. And resource shift, which isn't happening because there isn't a resource to shift. And there isn't sufficient resource in the community to provide the services that, acute, eh, needs that get people out of hospital. So there's a frustration, personally I think politically I still believe in the ideals of the NHS.

There is frustration with the NHS Scotland quality strategy. The rhetoric of 'shifting the balance of care' is viewed cynically as simply doing more with less, *there isn't a resource to shift*.

Admin.

F. And at the moment finance is the massive, massive driver at the moment.... money has to be saved.

Not being listened to

There was a strong sense of frustration, with staff feeling that higher level management do not listen to them. There was one-way communication from the top down, and consultation was frequently tokenistic. There was a sense that even when line managers attempted to involve staff in decision-making that decisions had already been taken at a higher level. Suggestions from staff got lost in the layers of management. Junior staff felt unable to question senior staff, and just got told what to do.

NAHP.

F. And it is disempowering if you raise concerns and say 'this is not good practice, this is a risk' and to have that ignored and think, and then that happens, you know, that happens too often. People will get completely disengaged if they are not being listened to.

Admin.

F But they just sort of, you know, just, just platitude. We'll listen but we're not going to take any notice anyway. We've made that, that's been signed and sealed and we've made our minds up.

Admin.

F1 Yes and we really often end up finding out about things just through an instruction.

I Hmm.

F1 And working backwards.

I Right.

F1 Which is the opposite really of, of, you know, involvement. So very often decisions are taken. And, and that really leads to the lack of empowerment because we are not able to actually make big decisions or to contribute rather to decisions.

I Right hmm.

F1 It's already made.

F2 It's already made.

F1 Sometimes you'll hear the phrase 'above your pay grade'.

I Oh really?

F2 No I haven't come across that.

F3 That's not very good.

F1 There's a lot of hierarchy within the NHS.

Staff are cynical about consultation.

NAHP.

M And sometimes you wonder to what extent your contribution really filters through to change.

I Right, that's interesting.

M Or whether it's, well there...

M ...well that's maybe slightly cynical but you do wonder whether, um, consultation is a, not lip service but, you know, it doesn't really have teeth. It doesn't really make that much difference or maybe you just have to do what you have to do anyway at the end of the day

NAHP.

F. Hmm and I think the, my management are great in that they try to involve you in decisions but the cynical part of me says that the decision's already made, thank you very much for consulting me but we have, the, the kind of thing that's been talked a lot about in my service at the moment is workforce planning.

M Mhmm.

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F Workforce planning, workforce planning and we'll involve you in this workforce planning. And I'm like basically that's your way of trying to get me to do more for less but you're just calling it a different name.....And the decision has already been made. The, the policies from above are just, you know, yeah filtering their way down, down to us. I think it just feels like just get your head down and do what you are being told to do and meet the targets that you have to meet.

Criticisms of management

Staff felt that there were too many layers of management. There was a weary cynicism – ‘management’ have not got it right in so many ways. There was an understanding that there are difficult constraints, but a feeling that staff are being asked the impossible and that management does not know the implications of their targets etc. Staff however are at the front line trying to implement the cuts. There was a lot of uncertainty. You just have to keep your head down and meet targets.

NAHP.

F You quite often read Team brief or Connect, all of these magazines, how great we're all doing, this is going on, that is going on. But we read all these things and we don't necessarily feel that that's how life really is.

NAHP.

F I think some if it is just general lack of understanding..... that you are having a conversation with somebody who is maybe two or three steps up the ladder and they fundamentally do not understand what it is you are trying to do.

There was felt to be a lack of positive feedback. There was a sense of an ‘upstairs/downstairs’, and some staff did not feel that they were treated with respect. Good management should involve staff in decision making. There was a fear about sharing things from practice – it would be changed, diluted or you would not be allowed to do it.

NAHP.

M Hmmm and sometimes if you share it too much, although half of you think ‘oh that's a good idea, I should share that’...

F Mhmm.

M ...but as soon as you put it out there someone will tell you ‘oh you shouldn't be doing that’.

F Mhmm.

M ‘Oh you can't do that’. And it doesn't matter whether it works for your area, works for your staff, works for your patients. Someone will come along and say ‘well oh no we want to change that. Oh no we want to do that globally. You can't just do it locally’.

.....so you've got, there is the fear factor..... it will be changed, it will be diluted or you won't be allowed to do it.

There is a sense of not being understood by management and those responsible for strategic decisions in the organization, a discourse of ‘they don't understand us’.

NAHP

FI And I think it's because the people who deal with the numbers don't deal with the people. And exactly, it's every single person has their own complexities.

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F2 *They do.*

F1 *And you can't just put them in one end and expect them to come out the other, you know. There are all the different agencies and it's essential that they are all involved because for the patients welfare. And I think it's easy when you, you are faced with the numbers, to kind of anonymise it. And that we are the ones that are at the coal face and deal with the people.*

The 'people who deal with the numbers' are characterized as having a sort of 'sausage machine' perspective, in contrast to those 'at the coal face' who 'deal with the people'.

It's such a complex set up though, (medical and management) ..And these two groups have a really quite uneasy relationship.

I *Right.*

F *Because they are driven by different things.*

I *Hmmm.*

F *Money by managers and patient care by consultants [laughs].*

F *They've got different goals from, from the consultants.*

I *Right.*

F *There's absolutely no doubt about that. Em, they may think, well they, I don't know on paper if they'd say that. But, em, it's definitely the case isn't it.*

Bullying

Bullying is an emergent theme, and also one which emerged in reports produced after my research was conducted. Some felt that a lack of support permeated the organization.

Managers are under a lot of pressure from above. Staff commented on a feeling of fear, and some poor behaviour by individual managers, although equally some managers did not pass pressure down to staff.

NAHP

F *I think that's very typical of the way things are often done. I certainly have experience of that and I just repeat what you said, yeah yeah. The sort of bulldozer approach.*

Admin

F *I don't think (my manager) he has any support from his higher up level. Um, and I think it's just sort of like criticism criticism criticism forgetting everything that has been achieved. Because there's this minor little bit that hasn't. Um, and as I say I mean I take my hat off to him because he doesn't actually then cascade that in the same way as has been cascaded to him. He completely reverses it round and focuses on the positive rather than the negative.*

NAHP.

F *And they (managers) are under so much pressure.*

F *Yeah huge pressure.*

F *So much pressure ... and that's sometimes come across as bullying for them to try and get what they need to get done as quickly as possible. Because their jobs are, seem to be more on the line than clinical staff.*

I *Right yes.*

F *They are very much under scrutiny. It doesn't make for a happy workplace when, you know, we don't have a blame culture supposedly.*

3. Learning and Development

Root Code title	Child Code title (if applicable)	Code Descriptor	Reason for code	Number of excerpts
Learning and Development		General comments on learning and development	Obtaining views on L&D were one of the goals of the research	103
	Mandatory training	Comments on mandatory training	An emergent theme	48
	Informal learning, sharing	Comments on informal learning, sharing, creativity etc	An emergent theme	36
	Management development	Comments on management development	An emergent theme	1
	IIP	Comments on Investors in People	An emergent theme	10
	Resources	Comments on resourcing L&D e.g.. finances, absence cover	An emergent theme	27
	SHRD, managing L&D	Comments on managing L&D and SHRD	An emergent theme	0
	Skills	Comments on skills, what use the organizations makes of skills, skills training.	An emergent theme	28

Table 16. Coding frame- focus groups 3

Learning and development general comments

There were a lot of positive comments about L&D. It was felt that there were good opportunities and positive L&D experiences and support. There is a supportive framework for learning, with PDPs and KSF. There is a good structure for clinical supervision. It was noted that there was a strong learning culture in the NHS, and that staff did feel committed to the organization.

There was a range of suggestions for improving access to L&D, such as a dedicated room for online learning, training being more research based, for example looking at systematic reviews.

NAPH

F. It's a great system if it works. You know, for actually engaging people and, you know, the sort of people you are talking about.

NAPH.

F ... I really appreciate getting a lot of opportunities to just keep up to date with, with old things and also, you know, new things as well, new skills, new skills. I really appreciate that. And it's totally encouraged. I don't feel there's anything negative at all.

I Really? And you have no barriers to access for it?

F No no no, none, personally no,

However experience was mixed. Staff felt that some units were able to make more use of L&D opportunities than others. There were also individual differences in how staff made use of L&D opportunities. Not all staff had had the required annual PDPs. Some felt uncomfortable with the move towards more web-based training, for example for some mandatory training. Some did not feel happy that some development opportunities had to be taken in staffs' own time. Workloads and staff shortages often made it difficult to access L&D.

NAHP

F1 ...it is, it's a good, it's a great system to use (PDP). You know, if people use it.

F2 If people use it.

F1 But the number of people that, you know, you go down the clinical areas and say 'okay, what was agreed in your PDP', 'oh I haven't had one of these for two years'.

M It should be done every year [laughs].

Admin.

F1 ...Personal Development Plans and really I think they're awful. I think it's really the worst learning experience I've ever had, I don't find it one bit useful.

F2 No.

I Yeah.

F1 It's just multiple-choice questions, on the computer and it's multiple-choice questions on, on areas that are not even relevant to us.

F2 To us. no.

I Hmm, You don't know if its relevant to your job.

F1 We use the same website as them, KSF and PDP's, Performance development programme.

F2 And you get no study leave to do it.

NAPH.

F. I think it's gone a little bit too much towards information technology and intranet rather than personal contact.

Some staff felt there were few rewards for doing T&D.

Admin.

F1 You can't move, you can't go forward.

I You don't feel motivated to go on the course.

F1 No you can't get a pay rise, you can't get promotion. There are no incentives...

F1 ...literally, no incentives to do, to better yourself because there's just no, there's no...

F2 There's nowhere to go actually.

Staff commented on the potential for L&D to stimulate engagement:

NAPH.

F. I'm in a fortunate position at the moment which doesn't reflect on previous experience, because of it being a test programme. The programme comes with an intense learning package which is just amazing, it's fantastic..... it's a rolling programme of training. It's ensured that you put this into practice and you use it and you learn new skills.....

I Really and do you feel that's contributed to your engagement then?

F Absolutely.

Mandatory training

Staff had mixed views on the mandatory training. It was hard to fit that in on top of other requirements such as clinical supervision. In some areas there was very limited access to computers. Sometimes it was difficult to get a place on a mandatory course. Some staff tended to do the mandatory online courses from home. Some staff had problems fitting in their mandatory training.

NAPH.

F Do you know we've been so short staffed for three years that well mandatory training hasn't been done for what, before I arrived, about four five years, that is how short we are. So actually going on courses just is, doesn't happen.

NAPH

F Cause it's the first thing to get pulled when there's any pressures on anywhere, the first thing they do is pull people off study days or cancel courses, cancel study leave.....

F Even mandatory stuff that you are supposed to have.

Admin.

F Protected times is great in theory but the reality is of particularly now that we're in open plan, if I'm sat at my desk...

F Oh yeah.

F ...not answering my phone and not doing my job, the person next to me or the person opposite me is having to pick up my slack. And I know how I would feel in that situation as well.

F Mhmm.

F There would be that little voice in the back of my head going 'she's not finished yet, she's been sitting there for hours doing her tippy tapping or whatever she's doing'. And so I would feel guilty. And you're looking at your in-tray the whole time. And if you've not shut down your email it's going pop pop pop.

NAPH.

F. And the fact is that NHS Lothian can't release staff from the clinical areas because of all of these things. So we can't even, we can't even deliver mandatory training, never mind any add-ons.

NAPH.

F There's 28,000 people and if you can imagine that you need to offer 28,000 places across NHS, we just can't release that number of staff over a year. And NHS Lothian is never going to achieve.

Some felt that there was not enough clinical skills development. Some staff had experienced mandatory training as having little relevance to their jobs.

NAPH.

F. we get a lot of, courses to go on which aren't to do actually directly with nursing. It's all to do with, em, legislative stuff nowadays. You know, just covering everyone's back. And it just gets to the point where it's just, gets ridiculous, you know. And, you know, and so we waste a lot of time with that. We are really, you know, all you are wanting to do is get on with patient care

NAPH.

F Yeah the mandatory training part of it is my bugbear really.

NAPH.

F And you have these study days that you have to go to. They are very lengthy and time consuming and releasing a lot of staff to go to these study days. And they seem a bit almost pointless, don't they.

Informal learning, sharing

Staff made a lot of comments about informal learning and sharing. It was noted that a lot of sharing, coaching and informal learning already went on. Experienced staff pass on knowledge and skills to newer staff, sometimes informally and sometimes as part of a peer supervision responsibility. Staff who went on training courses were sometimes expected to cascade their learning onto colleagues. But there was also a sense that as everyone was so busy there was less time for informal sharing.

NAHP.

F The vast majority of staff are willing to teach and can see the benefits of succession planning in passing their skills on to the younger generation that's comingSupervised practice is encouraged, you get time to do that. You are buddying up with someone who takes you them in the clinical remit.....things like peer supervision and all those things are hugely helpful

NAPH.

F. It's sort of continual learning from one another.

NAHP.

M. But I think one of the things that I'm aware of is that it's, when we were talking about learning from your, your colleagues is that everyone is an expert in the area that they work in. And people are not credited enough with the amount of teaching that they do.

Formalisation of formerly informal learning was viewed with suspicion. It was felt that there were opportunities for broader approaches to learning in the workplace. For example, it was suggested that learning could be linked to research on practice. Admin/support staff also expressed an interest in being involved in research. It was noted that doctors had dedicated time for research but the same did not apply to nurses and AHPs.

NAPH.

F And then they want to share it in the team and, or be able to use the team's practice to put it in as research and be published. You know, which I think increases the self esteem of the organization and the team. And I think it's not just about, em, randomised control trials by doctors.

NAHP

F But I think that it is about keeping things local and keeping them kind of simple.

NAHP

F. I think there's a bit of a fear factor though as well. Because nowadays all research is supposed to be done expertly. And, em, and you know, service development is all meant to be done expertly and you have to write it up. And I just get very worried about that and anxious about putting

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out what you are actually doing for, for the anxiety that some person is going to say you haven't done this properly, you haven't done that properly. What about this, what about that.....You didn't reference that right, and, eh, you know, where's your control group and, you know, and what you are wanting to do is actually develop something that works for your area.

NAPH

F *We weren't allowed to or were not permitted to do the in-house training.*

M *Oh right aha.*

F *Things that the staff are very competent to do, you know....., competences all had to be drawn up and then they were all gonna have to, it's gonna take me hours and hours to get, I thought, you know, dinnae bother, I've just not got the time to do that..... So, you know, it's paperwork again.*

IIP - Comments on Investors in People

There were a range of views expressed about the IIP initiative. One person criticized it for 'trying to impose an infectious enthusiasm for our role.' There was concern that it was generally about 'box-ticking', had taken resources from other areas, or did not seem relevant to clinical areas of work. It was difficult to engage with IIP in a climate of financial constraint, job freeze and wage freezes. Others said there had been positive outcomes, such as greater clarity over organizational objectives.

NAHP

F *I think it's work in progress at the moment.*

NAPH.

F1. *I think it's a great concept this Investors in People but.....*

F1 *...I don't see how it's going to work within the financial restrictions we have.....*

This is, there is a great concept about 'yes let's inform the staff, let's talk to the staff'. But there's, they have no real idea about what our lives are like and how to marry up their great schemes with what we actually do.

NAPH

F. *Yeah it does seem to be a real disconnect and this is the first year that I've had any sense of engagement being a two way thing. Now suddenly we are trying to get Investors in People status suddenly all these miraculous things we've never seen before appear, like strategic objectives. I mean I know what my general manager's objectives are. I didn't have any clue that he had them, there hasn't previously been a sense that it wasn't just about us and our responsibilities.*

Staff are suspicious of IIP as a NPM discourse.

NAPH

F1 *...and Investing in People... Trying to impose an infectious enthusiasm for our role when we can't recruit and we can't, you know, get things replaced. That hinders our job satisfaction. you know, Investing in People specifically instructs us to have an infectious enthusiasm for our job. And if we did have it before we wouldn't have it in their presence just out of principle in my view.*

F2 *Mhmm yeah.*

F1 *Which might be a bit strong but you do get a bit like that, you know*

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The staff member is very suspicious of being '*instructed*', '*to have an infectious enthusiasm for our job*'. The whole IIP initiative is viewed with cynicism.

NAPH.

F. *But it is the master of irony isn't it. In terms of at this time when we are getting no services we've got Investing in People coming in. When people feel least invested in, of all times we've got Investing in People. I think NHS Lothian is very good at that sort of giving us things that sort of fly in the face of the evidence.*

Resourcing L&D e.g. finances, absence cover

This was a big issue. There were again mixed experiences in gaining access to training and clinical supervision. Some staff experienced difficulties accessing training. Some community staff felt that it was it more difficult for them than for ward-based staff. There is a willingness to learn, but the problem was lack of time available or protected time or staff to cover. Some felt guilty when they were doing training and other team members had to cover for them. Some felt that mandatory training took up all their available time and there were not time or resources to access other specialist training. Training budgets had been cut. Some felt that there was a lot of training available but others had different experiences. It was noted that in the past not all training available was used, and people not turning up for courses seemed an ongoing problem. Staff got pulled from training at the last minute as there was no cover available, including mandatory training. Some line managers were not supportive of training due to pressures such as waiting time guarantees.

NAPH.

F1 *It's the recognition, yeah. I think there's training opportunities if you want them.*

F2 *Yeah.*

F1 *The problem is getting the time to do it.*

NAPH.

I. *So that's barriers is something to do with staffing. Is that something, yeah, a common thing you think?*

F1 *Yeah certainly from my nursing colleagues I know that there's, they are not allowed to get bank staff in to cover shifts for people who are going on training. So, you know, that's, the training, like you say the training courses are there. There's maybe no cost attached in terms of fees. But just freeing up the staff to do it and covering those staff.*

F2 *Mhmm, covering those shifts.*

F1 *Hmmm.*

I *And do you think people are willing to engage in learning, is there a general willingness?*

F1 *Mhmm yeah definitely.*

I *Yeah.*

F1 *Mhmm.*

I *It's just .. the time available.*

F1 *Yep.*

F2 *Mhmm.*

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Admin.

F. I mean when I first came, which was August of last year as a new person into the NHS I mean there was a lot of training. You had all your mandatory training, you had your induction training, you had this, dah de dah de dah. Um, and certainly...there's not been anything that's cost any money that I've actually asked to be able to go forward for.

NAPH.

F1 NES is good. I find they provide us with courses which don't interfere with the budget.

F2 Chest/Heart/Stroke, same Chest/Heart/Stroke Scotland, they provide a lot of stroke related care, support and training.

Some staff are able to access some training due to a special requirement – money is available for specific specialist training. There seemed to be different experiences in different hospitals, with more encouragement to engage in learning in some workplaces than in others.

NAPH.

F. I know that I think that for all I have my kind of moans about not being acknowledged for the psychological training, the other side of it is I love, I love the training and I love my job. And in the twelve years I've been in the community and actually I'll say the first, I don't know, eight, ten years, it's actually unbelievable the amount of training you could get on and people not using it.

M Hmmm.

F So I could see why things had to change. And we had to get tighter and kind of review things and who's doing what and how are you using it, but it does, I feel kind of embarrassed sometimes when I know that there's other people got no chances. We have every chance, I've had every chance.

F When I was in the Royal in ..., em, if we weren't booking ourselves on courses we were getting taken into the office and asked why.

M Hmmm.

F You know, 'are things too much for you, you're not able to do a course as well'. And here if you asked to go on a course it's like 'oh no, no we've not got the money for that, we don't have the staffing, you have to do it in your own time, you have to pay for it yourself'. And it's like well, you know, it's for your benefit, the wards benefit.

F Yeah.

F It's, so why in Med, just another hospital, you were being picked up if you weren't doing the courses. And here you're getting knocked down if you do try and do any courses.

There was some resentment that doctors get allocated study time but this does not apply to nurses, AHP or admin/support staff.

NAPH.

F1. the doctors did get their allocated study time.

F2 Yes they got it.

F1 Whereas well we had to do it at home.

F2 That's right, they've got it in their work plan. It's not in ours, you know.

F1 Aha aha aha. And that isn't, you are right though, that isn't good and...

NAPH.

F We had this mandate for clinical supervision. And again I can't disagree with the mandate for clinical supervision, how to implement it. And the fact is we've been here before and we've just run the same thing again. This is the policy, implement it, with no support, no resources, you just feel 'oh god, it's going to fail'. You can't start something without the proper plan, the proper support. And it would, the benefit in terms of learning would be phenomenal for all of the staff. But to do it badly is almost worse than doing nothing.

Skills: Comments on skills, what use the organization makes of skills, skills training.

Again there was mixed experience, which seemed to vary across different locations. Some felt that their job made good use of their skills and abilities, but others felt they had limited opportunities to exercise all their skills. Lack of promotion opportunities due to job freezes meant that some staff were working at a lower level than they were qualified for, and were frustrated by the lack of opportunity to use their skills or further their development in the organization.

NAHP.

M With AHPs I think, because one of the things that's been around for a few years now is a recognition that there are many skills which exist within the organization. That you don't necessarily have to go looking for training outwith. Em, some, some you obviously do but perhaps formalising more how perhaps more junior staff access training from more experienced staff who have those sorts of skills within the organization.

NAHP.

F But within (x clinical area), um, where they are looking overall at the jobs then I would say yeah our skills aren't being used properly.

I Hmmm.

F And people are not encouraged to discuss or I mean I can think of quite a few instances where things have gone on for years which are no longer effective.

I Right.

F They are ineffective but still everybody is doing it because no-one will, em, say anything. 'It's no my job' or it's got to that point..... Yes that's perfect, yes it's nothing to do with me, above my pay grade....., it's because, I think, people are treated with, with little respect..... it's a two way things. If, if people are willing to listen and discuss, and take on board.....things then you feel valued..... you get this situation where skills and abilities and they are not being recognised cause lots of people have got lots to offer.

Some felt resentful that if they increased their skills the organization benefitted, but they were required to pay for themselves and /or train in their own time.

There were a lot of positive comments, for example on sharing of skills, and it was recognized that there were a lot of skills in the organization. Staff were willing to share their skills and their knowledge, both clinically and academically.

Some felt that there was too much focus on mandatory training, not enough on ongoing skills development. Some felt they were actively discouraged from performing certain procedures that they would have done in the past.

NAPH.

F. 'My job makes good use of my skills and abilities' (survey question), that's not from my experience.... when I worked in (X hospital – previous post).... as soon as, em, we were on the ward, its make sure you have done your venopuncture, your cannulation and all the rest of it. And now it's

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like 'oh you shouldn't be doing that, that's a doctors job. No no you'll just, you'll just make them lazy'. And I say 'I want to keep my skills up to date'. 'Oh no you shouldn't be doing that'. And so you are actively discouraged from doing it basically.

NAPH.

M I think what it comes down to is you are on (x) ward and, you know, well I'd be really interested, you know, I've worked in the community for years but you go for community jobs and it's like 'well I haven't had CBT training, I haven't had XY, it's all these psychological therapies'. And say 'well can I maybe get some of that now'. And I think 'well no'.

F Well you can't use it in the wards cause you've no time.

M Well exactly.

F I hear my friends say that

M I've got lots of skills, I've always been working in mental health for the last twenty years. I think I've got a lot to offer but, you know, I don't have this particular skill [laughs]', you know. And it's like door's shut, door's shut, door's shut. And it's great, I think 'well where is the opportunities you say. Where's the potential for me to develop yeah'.

Admin

F. I'm responsible for something like (250 x) staff within Lothian. And I have (x) supervisors that manage certain amounts of staff in that. Everybody has a Personal Development Plan. Everybody has a six monthly review. And they are asked, you know, what is it you would like to do in the future. Where do you see yourself in one year, three year, five year. Now if somebody was tae say 'I see myself in your job in that time', I would do everything I could to get them on to the proper courses to give them the experience and, em, the academic development that they need to get them there. There's other members of staff that will say 'well actually I'm quite happy doing what I'm doing. I'm not looking for any development'. And you cannot force people to have that.

NAHP.

F. Even in our (x) department, there's a couple of girls in outpatients doing MScs.

I Hmmm.

F And they are doing really complex MScs, and they are taking a lot of their own personal time, annual leave, paying for it all themselves, getting no help from the department. But the department's benefiting from their skills..... So the problem is everyone is trying to improve their own personal development and then it's classed as CPD. So you are saying, 'oh why should we do this if we are not getting recognised'. But then if I go 'but it's for your own professional development, you know, so you can pass their gateway and KSF and things like that'. So I totally appreciate that. But then there's very little recognition for what you do because now you don't get pay rises. You know, it is quite hard to kind of keep motivated.

It was noted that some had more interest in developing their skill than others.

One suggestion was to formalise how junior staff access training from more experienced staff.

The next section presents the analysis of the findings from the interviews.

Chapter 6.2 Findings and analysis – interviews

Not surprisingly the interview respondents expressed different views on some matters than focus group participants, and had some different priorities and concerns. I have presented them on the basis of similar codes to focus groups, because that was the format for organizing and analysing the data, and to facilitate comparison with findings from the focus groups. I have indicated where interviewees were external to NHS Lothian by a symbol (E). (Note R= Respondent, I = Interviewer).

Coding frame – Interviews

1. Employee engagement

Root Code title	Child Code title (if applicable)	Code Descriptor	Reason for code	Number of excerpts
Employee Engagement comments		General comments on EE	Participants in both focus groups and interviews were asked to comment on the concept of EE.	30
	Familiar with the term EE	Are participants familiar with the term EE, and other terms they use. Comments on measurements of engagement	I was interested to find out what people knew about the concept of EE and identifying similarities and differences.	7
	Barriers to EE	Comments on what gets in the way of EE	Understanding the barriers and drivers to EE were a goal of the research	7
	Drivers of Engagement	Comments on things that facilitate EE		5
Locus of Engagement	General comments	What people say about the locus of engagement	An emergent theme from the focus group discussions which also appears in the literature	1
	Engaged with co-workers/team	Locus of engagement is with co-workers or the team	This was mentioned a lot in the discussions	4
	Engaged with the organization	Locus of engagement is NHS Lothian	EE literature suggests that EE is with the organization goals.	1
	Engaged with the patients	Locus of engagement is patient care	An emergent theme	0

Table 17. Coding frame- interviews 1

Employee engagement comments, and familiarity with the term

The interviewees, as HR and L&D specialists, had more familiarity with the concepts included within EE and were more overall focused on organizational aims rather than their specific medical specialism as the health professionals were. They used more 'management' terms with statements such as '*our bottom line is around patient outcomes*' and EE '*ties into some of the performance architecture as well*', and were familiar with concepts such as the learning organization. They were comfortable using the term EE.

R(E) ...employee engagement would be an academic construct to describe a number of things that people would have called motivation or satisfaction....and it would be a proxy for all those.

R. We use the term 'staff experience' to cover what is essentially employee engagement. I don't think the term would ring a chord with most people.

R I think it is useful, absolutely, in the NHS. I wonder in some ways if the term has got an association that's a bit dated. I think also in the NHS there's the potential for confusion.....we've got such a strong, erm, way of working with partnership working.....And I think the term might have a connotation of trade unionism, engagement.

The term 'staff experience' essentially refers to employee engagement. In this interpretation, health boards and staff teams appear to have a lot of initiatives on EE. There is a raft of things around engagement in the organization. The NHS Lothian HROD strategy espouses engaging leadership, living values, the patient experience, and has introduced a focus on the psychological contract.

R(E) Yeah so as a general observation Claire, the area that you're looking at is of vital importance.

I Right.

R You know, that that's just straight off.

I Yeah interesting, yeah.

R The delivery of services, it's entirely through staff. 70% of all of our costs are staff, you know. We measure activity in, in millions of hours of contact with staff.

I Yeah.

R As an NHS. And so therefore, you know, the, employee engagement is absolutely vital.

R And I think that, ...I think with employee engagement and with learning, I think in health that...if we don't get that right with our employees, then they will not get it right consistently with the patient services and care.

EE was seen to be multi dimensional and complex. As one respondent stated, people working in the NHS might use different language to business organizations, but there are shared values in the organization. Most felt that EE is of vital importance in the NHS, as the delivery of services is entirely through staff.

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R.(E) yeah and so therefore, it's an interesting question is to say how much does the professional academic literature and the jargon that comes from it help that as opposed to a kinda formulaic approach to employee engagement. You know, cause I think it, the way that you've described it, it's multi dimensional, its multi factorial and it's complex.

It was recognized that the NHS Scotland bi-annual staff survey had limitations. Participation was down and the data were not felt to be of continuing use for action planning. It was considered hard to get a true picture of staff experience in the organization as people's experiences vary so much. It was noted that '*as the NHS expects staff to be person-centered, we also need to also be alert to staff experience*'. Moving on from the Scotland-wide NHS staff survey, a group of HR/L&D specialists were establishing a pilot project, with the aim to build a rich framework and set of metrics to be applicable for the NHS in Scotland, to replace the current staff experience survey.

It was felt that the term EE was relevant to the NHS but could cause confusion with partnership working. The Staff Governance Standard enshrines a commitment to engagement and involvement, based on a partnership model of employee relations.

R. (E) Engagement is locked into the governance systems of the NHS. Clinical governance, corporate governance, staff governance.....

R. (E) We have the following conditions: No compulsory redundancies; Reasonable pay levels; Special schemes for leave, leave policies, sick pay. The NHS has good career opportunities if you take them.

R. The focus would be on improving or embedding that in a psychological contract. You know, this is what we're giving you guys. You know, we're not making you redundant but the deal is we want you, want you to come back to us. We want your sickness record and your sickness levels to drop, to reduce and that to be managed.

Barriers to EE

It was thought that barriers to EE might include workloads. It was noted that not all managers had had any management training, and management style might impact upon engagement.

R. I suppose like any big organization we've got areas where, erm, the leadership approach is very, is transformational. It's very engaged, we draw on adaptive leadership. And we've got areas where that's, that's less so. And....so I guess in terms of what might get in the way is very transactional leadership approaches.

R ... There's a reason why people aren't feeling engaged because maybe their managers are blocking that engagement because they are feeling threatened and under pressure. I mean I'm sometimes talking to groups of people who have been in a post for ten, fifteen years and not had any management development and they're in charge of people.

A culture which did not allow failure was also a barrier.

R ...There's the aspirations of the organization to be, erm...to be top in all ways to the benefit of our patients and staff. But I think paradoxically that also brings pressure in a way because how do you fail?

I Yeah.

R And if you don't fail, actually. Ever. I'm not sure that's possible in terms of learning. So there's something about...where actually if you think aboutWe are here to deliver patient care so how on earth could you fail. How could you manage that.

I So that's not provide space for learning if you can never...

R You can never fail.

R Yeah I think there's, there's...there's a culture which is, it's not okay to fail. It's not okay to get it wrong..... Yeah. It, it may well be as an industry because safety runs up the spine.

I Yeah.

R So...how do you, how do you judge the risk?

Drivers of engagement

It was suggested that staff needed to be involved as well as informed. The role of line managers was seen as important to create a climate of engagement. They were seen as crucial in locally interpreting what is happening in the wider organization. Learning and development can be a driver of engagement when it goes well.

Locus of engagement

It was noted that engagement is a complex process – different for different staff. For example, for staff in the operational division, cleaners etc. engagement means something very different to clinical staff. The NHS has very diverse staff groups to understand.

Locus of engagement is with co-workers or the team

It was noted that staff focus on their job and their team, and that staff are probably committed and motivated at a local level, with their ward or department or office. It's a challenge to translate the organizational overarching goals, objectives, and demands, meaningfully for people. There was a relevant initiative given as an example. It involved a group made up of the nurse director, chief nursing office, charge nurses, and staff from education and training. Under the banner 'delivering better care', the group's job in reality is about 'how do we make all of this work meaningful on the ground'.

R ...I would recognise it really strongly and so if you looked at nursing, erm, people come in to do their shift.

I Yeah.

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R And they focus there and they are part of that team...in a way that's the organization.....and I think the challenge for the wider organization is how to... translate the organizational overarching goals, objectives, demands, erm, meaningfully for people.

I Another thing that came out (of the focus group discussions) is that I felt people very much identified with their work, with their team. Not so much with the bigger organization.

R (E) That's very NHS.

I Hmm.

R Very, very NHS.

Locus of engagement is NHS Lothian

As noted, there was seen to be less of a kind of corporate vision, more of a local focus.

However there was more of a sharing culture than in the past.

R I'm not sure if you went into the ward or an office tomorrow or if you went out there just now and asked about that..... But I'm not sure if we...goals and values are motivated to contribute to organizational success. They are probably committed and motivated at a local level.....You know, with their ward or department or office.

Locus of engagement is patient care.

Although this was assumed as an underpinning rationale for the organization, in terms of engagement of staff this was not really taken up by the interviewees with respect to discussion on locus of EE in quite the same manner as by staff in the focus groups.

2. NHS Lothian and the NHS as a place to work

Root Code title	Child Code title (if applicable)	Code Descriptor	Reason for code	Number of excerpts
NHS Lothian		Views on NHS Lothian	It was interesting to note views on NHS Lothian as it is the employing organization.	32
The NHS		Comments on the NHS, history etc.	A range of views were expressed on the wider context of the NHS	6
The current climate	Cuts etc	Also includes the policy framework	An emergent theme	16
	Targets.	Working to targets, often set by Government, e.g. waiting times. An emergent theme.		2
	Workload, pressure	Comments on workload and pressure	An emergent theme	1
Organizational change		Comments on organizational change	An emergent theme	3
	Change management	Comments on how change is managed	An emergent theme	3
Comments on management		Comments on management and managers	An emergent theme and also one which features in the literature of EE	10
	Not being listened to		An emergent themes	0
	Criticisms of management	Comments critical of management and managers	An emergent theme	5
	Bullying		An emergent theme	1
	Teams	Comments on teams, multidisciplinary working etc.	An emergent theme	0

Table 18. Coding frame- interviews 2

NHS Lothian general comments

It was noted that NHS Lothian is a highly complex organization. The organization was created from several different organizations coming together, so there was a history of different organizational cultures. There are several clinical directorates, e.g. Surgery – also medicine, women and children (maternity and paediatrics), and mental health. The organization is a complex mix of people and services, with many different groups, disciplines, and subcultures.

R. It's got a history, a long historical tale to being separate organizations that came together.

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R ...when the separate organizations came together they came, clearly they each came with their own cultures. But they came with their own set of beliefs and expectations around what learning and development should be in place. And also if that should be rewarded. And if it was, how it should be rewarded. And what would the organization support.

As an NHS organization, it operates in a political context, and there is a need to balance demands from government with other stakeholders. There is a need to communicate policy developments to staff to assure compliance with government directives, and manage monitoring and scrutiny visits. There is a lot going on - staff governance standards, issues around clinical governance and financial governance, staffing issues, introduction of PDPs and the KSF.

R ...some a' the challenges., the demands around efficiency and change. And I suppose in amongst that there's the bit which, which can be hard on the ground to see. But is the organization which is about, erm, balancing what is, demand led from government. And which clearly in Scotland cause we're small. It gets to us very fast.

I Right yeah.

R Erm, and balancing that with sometimes what people might desire on the ground.

I Right, not being sort of part of the decisions about priorities yeah.

R Things like HEAT targets that get set.

I Yeah.

R Nationally and then absolutely a requirement and there's no debate cause if the minister says this is what you're gonnae do, we have to do it. I think on the ground people are feeling that the impact of that through the scrutiny visits.

I Right.

R Or the mere fact that they're called scrutiny visits, that's a challenge.

The situation is contradictory and complex. The organization wants staff to be innovative but is concerned about risk.

R. It, it may well be a as an industry because safety runs up the spine....

R. The service needs to run 365 days per year, we can't stop for staff training, and when we get it wrong it can be disastrous.

NHS Lothian has a relatively highly educated workforce – most have degrees, for example nurses, lab technicians, and managers. At the other end of the scale are lower grade staff, in catering etc. who tend to have less qualifications. There were issues around career progression and succession planning.

There were seen to be issues around clinical workforce culture and attitudes towards the organization. Doctors do not have a normal employee employer relationship with the organization. Government determines doctor's pay, but government does not hold the contract with staff. Senior medics were seen to be less focused on seeing themselves as working for NHS Lothian rather than their medical specialism.

The NHS

Anything impacting on staff pay and conditions is negotiated with Scottish Government within an overall framework of partnership. The Scottish Government (SG) is ultimately responsible for management of medical and nursing staff numbers only, but not for not allied health professions. There is a system of Partnership forums, and Staff Governance standards are reported on annually.

R(E) And I guess that the, in the act around 2001 there was a decision taken that to make sure that the staff governance standard was adhered to and not just given lip service to, it became a requirement. And every board has to report on it every year.

There have been a lot of changes since 1995 – from internal market, to the introduction of GP fund-holding, acute and community hospitals, acute and primary care trusts. At end of the 1990s the internal market done away with, Chief Operating Officers displaced Chief Executives. So a lot of senior jobs were merged, which left a lot of senior people in the system with changed roles. There is ongoing restructuring in the NHS, and others significant developments e.g. the creation of NHS 24.

Long-term sickness is an issue. One aim is to drive down sickness absence to improve efficiency. But it was stressed that they were not seeking to make people who are ill come into work. It was noted that another agenda in the public sector is diversity, which may include offering employment to people who may have difficulties entering employment in the private sector. If they have health issues for example this may mean more time needed off work, which results in a difficult balance regarding the policy of reducing sickness absence.

R(E) The main, the, how that's organised is you're aware, I'm sure, of the staff governance standard? Now that enshrines a commitment to engagement and involvement.

I Right.

R Erm, it's based on a, a partnership model of employee relations. And that goes back to pre '99 when the trusts were first being set up in Scotland.

I Okay.

R After, erm, when devolution was on the way. And there was an acknowledgement that, erm, that health would be one a' the biggest things devolved.

The current climate

There are key targets for the NHS to deliver e.g. waiting lists. Workforce planning is a significant issue, the challenge of ensuring that there is an appropriate skills mix and numbers of required professionals available and trained. The Scottish Health Secretary made a commitment in 2010 to no compulsory redundancies.

Current initiatives are reshaping the medical workforce – the working time directive, skills mix, focusing on making services more efficient. There were issues such as culture and attitudes, and training. Service redesign is an issue.

Financial issues are key, with the need to deal with year on year budget reductions. Discretionary spend is targeted, e.g. a ban on recruiting temporary staff, and they have stopped using agency nurses. The organization aims to lose 3000 jobs by natural wastage. There are quotas for staff reduction, and this means that people will need to work harder. One in 4 senior managers need to go, with the aim to achieve this by 25% natural wastage.

The Agenda for Change has a big impact. In the past, before introduction of the KSF, staff would be rewarded for long service not competence.

Big changes such as Lean methodology have brought down waiting times.

I Do you think there's a learning culture that's supporting adaptability, experimentation, learning and innovation?

R At certain levels yes. I think definitely the five by five by five. I think the, erm, LEAN stuff. They are, helping people to become innovative, at the time there wasn't the stick as much. It was more, now it is a bit a' stick. You know, we have to get something changed. Cause the budget ain't gonna be the same, you know. So there's a pressure to change and be more efficient. Whereas before it was less urgent if you know what I mean...It's thirty two weeks to wait for a CT scan. Now it's only four because a' the, you know, the innovation, the thinking, the LEAN stuff. I mean that's fantastic! I mean really great numbers I could give you if you wanted

However people struggle with the constant ongoing change. There is more pressure to be efficient. There is more 'stick' than before, such as HEAT targets. There are a lot of changes and uncertainty about the future.

R We have a 5% reduction last year in our budgets.

I So the budgets for learning and development as well.

R And next year we're gonnae have a 5% reduction and following year, a 5% reduction. So all across the functions now, 5% reduction. So the pain and anguish that you go through last year will have to be repeated this year.

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R. My job it's questionable about what it'll look like. Erm, so I've got the anxieties. There's people in my team got anxieties. So it's hard to be innovative when you are feeling a bit anxious. And if that's affecting me like that, what's it like in the wider organization? So there are a lot a' people who are just treading water, just waiting to see what happens. Plus personal circumstances, I'm doing my own learning as well. So...

Targets.

There was a comment that *we have to translate targets so they are meaningful to staff.*

However, whilst targets formed part of the backdrop, discussion on targets did not feature so prominently in the interviews as they had in the focus groups.

Workload, pressure

There was a recognition that because teams are leaner and smarter they cannot spare people to go on courses. And a lot of people don't turn up, which is a shame because there are waiting lists.

Organizational change

As mentioned there were a range of big development programmes, for example the Sick Kids, Royal Infirmary, and Royal Edinburgh hospital projects.

R. Yeah, I mean I think there's an ongoing, the constant change.

I Yes, yeah.

R That people do struggle with.

R. The Scottish patient safety programme.Big big programme, erm, led from the centre. But with lots of, input within the board. And it's predicated its modelling areas on small incremental change.

I Right, right.

R In terms a' cycles of change.

Change management

L&D in NHS Lothian are aiming to develop a transformational leadership style, but currently this is not yet applied in all areas. The staff survey pointed out a need to learn to manage change better, which also provides a stimulus for L&D.

Comments on management

It was noted that there are differences in management style amongst different managers. Some managers do not act as leaders inspiring staff to learn. Some line managers are not in favour of supporting staff to do L&D. This will affect the distance people feel from the organization. Managers are the only staff group with a high turnover. Some medics go into teaching and research, but not often as this is not very well paid, or into private work. There is in effect a 'golden handcuff' for medical staff.

It was noted that '*the good times are coming to an end*' – managers need to manage and lead. There are new pressures, and what kind of leadership is needed in this climate?

The psychological contract was considered an issue regarding the policy of non-redundancy, In return the organization is seeking to manage and reduce sickness absence.

R.(E) (Professor David Kerr, a major review done in mid 2000's). And he took a complete look at the NHS in Scotland. And...

R Erm, whereas most people said 'no we want our services as local as possible'. And that was kind of our mantra, as local as possible, as central as necessary. Anyway his, erm, characterisation, he said if the NHS in Scotland was a noise, it would be a passive grumble.

I Oh really.

R Yeah so people actually do moan quite a lot.

I Yes

R You know, if you went over to a group of staff here they would say 'oh it's terrible'. Even though we built a £170,000,000 hospital, they would find things to say.

R ... So it's hard for people to get on courses cause they're full or they can't get time off. Or their line manager is one a' the 30% who's not been sitting down wi' them having a good conversation about their needs. So there may be lots of assumptions being made about 'ach, you're good at your job, you don't need any development'. Erm, so there's a few variables going, eh, in that area, and maybe apathy, maybe people think, 'och I'm fed up wi' learning'. And there's not, there's no, if your manager or your leader's not inspiring you enough to learn and do and be better, maybe there are people who are comfortable with being mediocre and just being competent. 'I am good at my job. I'm doing fine, I don't need to do any more, I don't want to do any more'.

Not being listened to

This did not feature other than the general comments about managers.

Criticisms of management

It was noted that communication is a problem in a lot of NHS organizations. Not all managers are not committed to continuing development, although the KSF and PDPs have

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helped, and staff themselves have been active in taking up PDPs. Managers need to manage it, and this needs a culture change.

R I think, erm, well the, the...the stories I hear sometimes are just quite appalling about what some people say to, to their staff and how they say it. And you just despair. Why is that not getting dealt with? Do they know what they're saying? I mean we tried the 360 (360 degree feedback) here but there was quite a negative response to it. Erm, the sense was it was a great excuse to give people a kicking, you know. Erm, it wasn't genuine, I suppose. And there needs to be a way of people seeing how, what effect they have on others. Maybe that's why you're not getting employee engagement if, because behaviours a' the managers is, well if that's what they're like then they're all saying why should I bother if they're no bothered. Maybe there's some a' that happening.

Bullying

This topic did not feature in the discussion.

Teams

Comments on teams, multidisciplinary working etc.

Again this did not feature in the same way as in the focus groups.

3. Learning and Development

Root Code title	Child Code title (if applicable)	Code Descriptor	Reason for code	Number of excerpts
Learning and Development		General comments on learning and development	Obtaining views on L&D were one of the goals of the research	49
	Mandatory training	Comments on mandatory training	An emergent theme	5
	Informal learning, sharing	Comments on informal learning, sharing, creativity etc	An emergent theme	7
	Management development	Comments on management development	An emergent theme	8
	IIP	Comments on Investors in People	An emergent theme	9
	Resources	Comments on resourcing L&D e.g.. finances, absence cover	An emergent theme	3
	SHRD, managing L&D	Comments on managing L&D and SHRD	An emergent theme	3
	Skills	Comments on skills, what use the organizations makes of skills, skills training.	An emergent theme	9

Table 19. Coding frame- interviews 3

Learning and development general comments

One key aspect of learning and development is about supporting achievement of the organization's objectives and goals and requirements, whilst also fostering and supporting learning for individuals. The NHS operates in a very political context, which has implications for L&D. The challenge for L&D is to bring together different government directives and translate them into meaningful L&D initiatives. To create opportunities that enable people to learn but also enables them to demonstrate delivery against criteria or the targets from government.

R I think it is (a public sector issue) I think that's a huge pressure for people on the ground.....

R And it also influences learning and development strongly because clearly when you know what you are gonna be scrutinised against, then you absolutely need to make sure that we've got the learning support there for people. And...that may then also influence how you frame your plan, your resources.... it will influence decision making around resources.

L&D is supported by the KSF. In NHS Lothian the KSF is being rolled-out by a project team. There was a target for PDPs for all to be in place by end of April 09. At the time of the interviews one third of staff had not had a PDP, which was an issue for L&D to address.

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Electronic KSF was being introduced, an electronic record on a database, but compliance was poor. KSF provides an incentive for staff to engage with L&D. Clinical staff also have accreditation and validation processes prescribed by their professional bodies. Nurses and AHPs have CPD, but here is less opportunity for support staff, for example facilities.

R.(E) And if you think then as, as a, a contractual requirement of the Knowledge and Skills Framework, and the reason that you got the pay rise through Agenda for Change is that everybody is required to have a personal development plan.

L&D needs to be more focused due to financial constraints. L&D covers a wide range of functions, including management development, and GP staff training. L&D runs corporate induction for 60 people per week, and other mandatory training. Issues such as healthcare generated infection can create big training issues that have not been planned for.

Issues in the organization include budgetting, pay, staffing levels. This needs a culture change which has to be managed by managers. Some other issues are performance management, recruitment and selection training, and talent development. Issues vary across different staff groups. For example, for Estates, H&S regulations are an issue.

R Challenges for learning and development.....In terms of delivery it's trying to keep in touch with what people need as opposed to delivering what we think you should have....And what mandate do we have for delivering what we deliver in the absence of a formal training needs analysis. So what we have done as part of Investors in People is we've set off a formal training needs analysis across the functions.

Coaching is big area of development, and the aim for a coaching style of management and further introduction of mentoring. E learning is widely introduced, and a learning management system

R Huge, coaching and mentoring, I think, I think I would get more out of mentoring or coaching five or six key people than...a session a month on leadership. Because these key people could be the key to...almost like pyramid selling, you know. If they're at the top and they show like, you know, leading by example to the five supervisors below them, they're a whole...structure that's probably improved just by one conversation or six conversations over the set piece. I'm not saying they are guaranteed to work. But can you see where I'm thinking about, you know.

I Yeah, yeah.

R There's a lot of leading going on here that's pretty ineffective...

The KSF provides a framework for career development. There is a whole range of opportunities at all levels, with a spectrum of learning from formal to informal. Learning does not just come through courses but through a whole range of interventions. If you make a case there are opportunities for staff to engage in career development.

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R So that hopefully, erm, everybody coming into our organization in the future will be able to see a potential career path

R.(E) ...you get the whole, you get the whole spectrum. You know, we have people doing PhD's. We've got people doing masters programmes. All the way through to micro modules for, erm...we had here, I gave the certificates at a session for allied health profession support workers.

It is a challenge for L&D to provide a framework for learning.

R. I think there, I think overall there is a learning...culture, erm, to varying degrees in different parts....., I could probably give you examples in the majority of our services.....Of where there are strengths around a culture of learning. I could equally probably give you examples where in many of our services that's not as strong..... So I think it's quite a dynamic...process for us.... For us in the sense of...erm, being on a journey to that and actually probably a journey that we'll always be on.

One area of weakness in L&D was in evaluation of learning. There is a need to be more creative in thinking about L&D. They have been reactive in the past.

Some staff have a sense of entitlement – they assume that if they do training then there should be a reward, a new job or promotion. That's not possible now, a new culture is needed.

It was noted that L&D can provide a bridge into engagement with the organization's goals.

R I think the challenges for learning and development, in a sense, are being, I guess it's that paradox about...with learning we understand that, that, erm...nobody's gonna, or nobody's gonna ever hit, perfection but nobody's gonna get it absolutely right, erm, on the whole. There's times when we do expect people to have a, a journey in learning. But if the organization demands success and absolute safety then I think the challenge for learning and development is in finding the ways to deliver and support their learning, erm, that supports the learner journey. But inside a frame, erm...there is about actually there's a, either you can't get it wrong or there's a narrow margin to get it wrong because potentially there's no scope to get it wrong.

Not all managers are committed to continuing development, although the KSF and PDPs have helped. Career progression is an issue for lower grade staff, in catering etc.

Succession planning is also an issue, and not one that the NHS does well.

Mandatory training

Mandatory training is a big part of L&D. Mandatory updates for clinical staff include fire safety training, manual handling, equality and diversity, resuscitation, and infection control. L&D is responsible for clinical training and for non-clinical. Non-clinical training covers violence and aggression, adult/ child protection, etc. They are delivered either face-to-face and via e-learning/blended delivery. Staff should have updates every 18 months – ideally this

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would be annually but it is too costly, the main problem being that the organization cannot release staff to cover this. Mandatory training is the biggest challenge when you need to cover 28,000 staff.

People often don't turn up when they have booked on training. E learning provisions does not suit all staff, and some complain that the context is too generic.

Its difficult to deal with aspirations of those staff who want to develop but need to cover their mandatory training first.

Informal learning, sharing

It was recognized that learning does not just take place on courses and during formal learning opportunities. For example it would take place in a short life working group.

A high percentage of staff have been through higher education- they are comfortable with formal learning, but have to learn new ways to learn. We need to help people to learn smarter because of reduced staffing in L&D. There is a need to find ways to engage people in learning, sharing, learning from one another.

R ... I think it doesn't help that our culture, you know our organization has a huge percentage a' people who've been through higher education. And through higher education in the last, not in the last five to ten years, a lot a' people that are in charge. So they are comfortable with the class, twenty in their room, person at the top, full of empty vessels. And not thinking how it is now where it's totally different. It's almost the other way around.....people finding out for themselves in their own way. And the learning is very different, sharing, learning from each other. It's almost hard for people here to understand. But that's how we could be passing information on to others.....

R I mean what...it's hard enough to get people to engage with it anyway sometime. Some people say that I was sent by here, I was sent here by the manager. Just...okay. What are they gonnae learn or pick up? I mean you might be lucky, might catch them, they might get actually quite engaged. But, erm, we could be smarter. And we need to be smarter because anybody who leaves is not gonnae be replaced. So what used to be twelve sessions a year will have to be eight.

R (E) I think we aspire (towards a learning culture) and I think we're at different places on the journey in different areas. The Scottish Patients Safety Programme's probably been quite a good example of where I think they're doing quite well, erm, in that one a' the things that's emerged from that clinically are, erm...in acute wards, erm, are safety briefings in the morning where the whole team get together.

I Right.

R The whole team who are gonnae be on that day. And they'll talk about what's been going on in relation to some of their patients. You know, what's come up in the last day or two. What might be particularly important for today. What's, what's around in relation to, to safety and to some a' the quality aspects around it. So that, so there's a real opportunity there for shared learning.....

I And not necessarily something that you call training.

R Yeah, yeah, absolutely. Training in some ways is the smaller tip of it.

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I Yeah.

R So there's lots of examples like that, of...shared learning. And, and we're seeking to build on that....

R It might be, it might be, for example, saying, 'have you ever participated in a short life working group to solve a particular problem'. Well they wouldn't have seen that.

I No.

R They wouldn't personally badge that as a learning and development opportunity...

R. they might not be badged learning and development.....They might be, they might be badged service redesign groups. Erm, improvement teams.....it might carry much more clinically meaningful labels than HRD meaningful labels.....But what's going on in those groups is learning and development.

Management development

Leadership development is currently an important aspect of L&D work. Clinical people find management and leadership a challenge. There are new pressures in the changing context, and a question over what kind of leadership is needed. There are debates over the different needs for leadership and for management.

Competency models for managers were being introduced, aimed at three levels of supervisors, middle, managers, and heads of department. The aim is to benchmark individuals against the competencies using PDP, which will look at their ambitions and professional development needs.

There is a management development programme for senior staff. NES have provided a leadership framework. The model is one of adaptive leadership. There are masterclasses and action learning sets, and networking opportunities. Underpinning this is an online learning service. Mentoring and coaching are also becoming important to back up classes.

It's a big organization. There are leadership subcultures, not one culture.

It can be hard for people to apply models of transformational leadership in their area of practice, if that is not the prevailing model.

Managers have been mandated regarding IIP.

Comments on Investors in People

IIP provides a framework and structures and a corporate action plan. It is based on the planning cycle of Plan, Do, Review, Evaluate. It is underpinned by the KSF and PDPs. An action plan must state NHS Lothian aims and objectives for each service

Managers need to manage IIP, and this requires a culture change. CHP were evaluated against a template, and the result was that 60% of staff said that they were happy with their manager and developed. Whilst nurses and AHPs have CPD, this is less developed in facilities. Estates however have to follow health and safety regulations.

IIP pilots are being carried out with a representative sample - Day and night shift, male /female, PT/FT. Staff will be needed to continue to deliver after initial accreditation.

IIP want evidence not simply paperwork.

Resources

It's a challenge to save money in L&D as the costs are mostly staff costs. The challenge is to deliver more for less, and in different ways. Innovative ways of delivery and resourcing L&D are being explored, for example using drama students to role-play for management courses.

Staff have not had equality of access to training in the past but this is being addressed.

TNA might throw up things that they don't have the resources to deliver.

R ...I'm keen to see how we can, erm, deal wi' some a' the people stuff because that's the hard stuff to do, I think. Erm, and you could send people booklets and give them online learning. You know, you could do tons a' that stuff which is fine. But people don't like that. They get bored with it, it's dry, it's annoying. But the interactive stuff, you think we've got an opportunity to work wi' X College, for example, who have got drama students who are desperate for practical experience. So working with HR, I think about the difficult conversation and stuff. So if you do it in-house with them...

Skills

Soft skills are now integral to the medical education curriculum. Doctors, including consultants, now have to go through re-accreditation, validation, and to present a portfolio.

It's a UK wide initiative that's come from the Royal Colleges.

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Next 4-5 years doctors will need to revalidate, and the BMA will introduce compulsory re-validation every five years.

The KSF is now the biggest incentive to engage in L&D. In the past you automatically progressed but now you have to demonstrate that you match the KSF profile and evidence that you can apply your learning into practice.

I I what are the incentives for people to do learning and development?

R The KSF is the biggest incentive.

I Yeah. Is that linked to your salary now?

R Well sort of. It's, it's, there's this gateway that you come to. And I think in the past you used to automatically go on. If you've got evidence to show that what you do and know matches the KSF profile that you have...

I Right okay.

R ...then that's, that's you in a kind of positive light. But even that might just be you performing enough and not over and above. And it might be you don't know that and you don't need to go and learn and you have a conversation with your line manager who will show that you can apply this learning into practice. So therefore you're, you have the evidence you're at the gateway. But I suppose what we're talking about is going beyond that and, and inspiring people to bigger and better things and recognise when there's talented people and all that stuff. That happening under so much pressure is probably less likely to happen. That's an assumption that I'm, I'm worried that people just tick over. Well maybe that's fine for two, three years until we get out a' the, the bad time. It's an unknown.

Conclusion

This chapter has presented the analysis of the findings from the focus groups and interviews.

In the next chapter these will be discussed with reference to the research questions for the study. Key findings will be highlighted and implications drawn out.

Chapter 7 Discussion

Introduction

Organizations are filled with people who have their own interpretations of what is and should be happening. Each version contains a glimmer of truth, but each is a product of the prejudices and blind spots of its maker. No single story is comprehensive enough to make an organization truly understandable or manageable. (Bolman and Deal, 2008: 19).

The research, in taking a social constructionist approach, looks for patterns and shared understandings in the meaning-making activities of people. Each interview and focus group is a shared experience of creating meaning, providing insight into multiple realities of the social world. It is not a search for absolute truth, but an opportunity to develop layers of understanding. The interviews and focus group discussions not unexpectedly generated some very different findings, as well as issues that were significant for respondents but not immediately related to the research questions. Interviewees were professionals who were largely focused on the broader organizational context and the specific challenges associated with their work in addressing wider organizational objectives. This reflects either their positions as senior managers, or as L&D specialists (sometimes both). Focus group discussions tended to be more about staffs' experiences and perceptions, and reflections. Although some of these staff had management responsibilities, they tended to focus more on their specialist responsibilities and local work context. Whilst they represent individual perceptions the 52 people who took part in the focus groups do provide something of a collective focus as well, contributing towards a rich picture of the organization and of EE in the health service context.

As noted in Chapter 2 the initial coding and analysis of focus groups and interviews generated insights that led to the modification of the research questions. This was accompanied by further review of literature, some additional interviews, and generation of conceptual codes. The analysis presented in this chapter represents the outcome of this conceptual analysis, as illustrated in the third stage of the Thesis Conceptual Framework (Figure 3). Having analyzed the findings based on key analytical themes, I now relate the findings to the final research questions in the context of the review of literature. The review of literature highlighted the complexity and competing interpretations of the construct of EE within and across the 'practitioner' and research literatures.

RQ1. What meanings, purposes, attitudes and behaviours are attached to the concept of employee engagement in a given health service setting?

Employee engagement construct

The concept of EE which was presented to the focus groups (see Table 11) - how you think, feel and behave is directed towards achieving the goals of the organization – follows Shuck and Wollard's definition - 'an individual employee's cognitive, emotional, and behavioural state directed towards desired organizational outcomes' (2010: 103). Motivation, discretionary effort or 'going the extra mile', job satisfaction, empowerment, feelings of connection towards colleagues and to the organization - other reported facets of EE (CIPD, 2008; Gatenby et al., 2009) – were all discussed in the focus groups and interviews.

The term EE was not generally used by focus group respondents in their work, but staff recognised the component aspects and as such could see its relevance for the health sector. Interviewees were more familiar with the term EE, but also said it was not commonly used in the NHS. The term has potential for confusion with staff governance in the NHS, which commonly uses the term 'staff engagement' to refer to staff involvement in governance. Interviewees noted a raft of different initiatives in NHS Lothian, such as 'Living Values', which could be perceived to come within the domain of EE. Staff agreed with the literature (eg. Macleod and Clarke, 2009; 4-Consulting, 2007) that factors which could contribute to engagement included such things as open, two-way communication; engaging leadership styles; fair and equal treatment; reasonable working hours; career development and training; coaching and mentoring.

They felt that EE was an important concept for the NHS, as the delivery of services is largely dependent on staff, and engagement of staff would have a spin-off for patient care. It was considered that the NHS Scotland staff survey had limitations, and did not capture the nuances of staff experience relative to engagement.

Engagement was seen as a two-way relationship between employer and employee (Robinson et al., 2004). Focus group staff expressions of EE encompassed the essence of the term, as in the following representative quote:

F. I think most people generally want to feel motivated to do their job well. I think most people want to feel involved. I think they want to go home at the end of the day and actually feel that they've done a good day's work for a fair day's pay.

The concept of engagement provided a ready focus for the fieldwork discussions. As discussed in the literature review, engagement was seen to be multidimensional and complex, and may differ for different groups of staff. Key issues that emerge from the analysis are now examined.

Engaged at the organizational level

The role of the organization in facilitating EE is an important theme in the EE literature. Macleod and Clarke (2009: 8) note that engaged organizations have ‘strong and authentic values’ and EE is concerned with translating these values into day-to-day behaviours. This is certainly something that is espoused in the NHS Lothian documents examined.

Interviewees recognised that the organization is large and complex, and it is widely perceived as distant. There was a strong narrative from the focus groups that staff don’t feel commitment to NHS Lothian as such. Some staff were not clear on the overall strategies and goals of the organization. Whilst the organization may well be already communicating these aspects, for example in staff briefings, staff do not always ‘hear’ the communications, unless they are directly related to their areas of work. Interview staff were more aware of the significance for the organization of working towards targets, for example, whereas some focus group staff felt less aware of the ‘bigger picture’, as the following quotes illustrated:

F. But I feel so totally out of touch with the organization.

F. The board is some faceless thing.

Engaged employees are said to feel commitment to organizational values and to be motivated to contribute to the success of the organization. Whilst staff in the focus groups did frequently express a distance from the wider organization, they also had a very clear sense of their role and goals as professionals, which would seem to be largely in accordance with organizational values and objectives. From their own perspectives, which are all that I could assess in this study, they described being mostly engaged in their day-to-day work, in varying degrees. The research did not seek to assess their work performance as a demonstration of engagement, other than on this basis of self-reporting. Staff expressed strong professional values about providing a good standard of patient care and caring about their work, especially where they were supported by colleagues. Even for those who expressed aspects of disengagement, such as a lack of willingness or resentment when being

required to work extra hours, they spoke of being engaged with the actual work on a day-to-day basis. In some respects they saw themselves as engaged *despite* the organization. For example, staff said that they would work extra hours *for the patients*, even when they were critical of organizational or management practices. In this respect they could be considered more to be engaged as *professionals* than specifically as *employees* of NHS Lothian. This indicates that engagement of the individual employee is mediated by factors other than *organizational* goals and values.

The findings raise the question of how far it is necessary for all staff to express full 'engagement' with the overall organization when it is so large and complex. Is it sufficient for staff to be engaged in their more local areas of work, if organizational objectives are being met? In fact, even if staff could not comment on particular organizational strategies, overall the clear goal is seen to be that of patient care, which is also the main goal of NHS Lothian. Staff do seem to identify with many of the organization's values, despite it being perceived as distant, perhaps indicating implicit engagement rather than explicit. This again points to some limitations of the survey approaches to assessing levels of employee engagement, on the basis of self-reporting. For example, responses to a survey question about feelings about the organization may result in a low engagement score on the survey. But this may not be an accurate reflection of staffs' actual level of engagement. They may not feel engaged with the 'organization', but they are still engaged with their day-to-day work, especially where they can establish relationships. The locus of their engagement is more the work team, patients, and also their profession, as will be discussed further in this chapter.

The individual experience of EE will now be discussed with reference to the psychological contract, motivation and job satisfaction.

Engaged at the individual level: the psychological contract and EE

Another way of looking at the relationship with the organization is through the concept of the psychological contract, which has clear links with EE. The psychological contract refers to the mostly unwritten perceptions of staff about what the organization expects from them, and what they can expect in return. Individuals will have different perceptions of the psychological contract (Bratton et al., 2007).

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A recent report by CIPD/PPMA (2012) argues that public sector employers need to build a new psychological contract with staff; ‘underpinned by greater flexibility for individuals, skills and employability development opportunities, as well as good-quality people management and leadership to compensate for lower levels of reward and job security’. They also argue for the importance of recognising ‘employee voice’. So staff perceptions can be interpreted with respect to how they view the psychological contract and how far they feel the organization is going to meet their expectations. The following quote from a focus group illustrates commonly cited expectations about the psychological contract:

F ... if you regularly are going the extra mile.....if when you need the organization to be flexible with you, they can be flexible with you... so it's a sort of give and take.

As MacLeod and Clarke (2009: 8) express, engaged organizations demonstrate ‘evidence of trust and fairness based on mutual respect’ and where promises and commitments between employers and staff are both understood and fulfilled. MacLeod and Clarke’s comments do assume clarity of expectations from both sides. This does not fully capture the nuances that are assumed within the concept of the psychological contract, which incorporates individual differences in assumptions, and ‘perceptions’ rather than only clearly articulated expectations.

Interviewees were familiar with the concept of the psychological contract, and noted the requirement for new psychological contracts in line with NHS policy developments (Davies and Nutley, 2000). They suggested that the Agenda for Change included a new psychological contract, which was in the process of being embedded in the organization through such things as the KSF. But there may need to more understanding of the ‘unwritten’ aspects of the psychological contract. As noted by Murphy et al. (2006) the organization needs to pay attention to its side of the bargain. There was resentment expressed by staff in focus groups that indicates that staff do not feel that the organization is meeting their expectations of the psychological contract.

Engaged at the individual level : Job satisfaction and EE

The distinction between ‘engagement’ and ‘satisfaction’ is unclear (Macey and Schneider, 2008), so it is useful to analyse staff perceptions of job satisfaction within the context of this study of EE. Job satisfaction was regularly referred to by focus group participants, and some staff felt that it had been impaired, from issues such as the lack of promotion, and difficulty

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accessing training. Some aspects of their work seems curtailed, such as a variety of tasks that staff had previously performed but were not allowed, or not given priority. The following quotes from focus groups are illustrative

F. You know, so I suppose from that point of view my job isn't as satisfying as it once was.

F. I think it just feels like just get your head down and do what you are being told to do and meet the targets that you have to meet.

One point also raised was that the 'busyness' of the day meant that staff had to rush through tasks, and did not feel that they were providing patient care to as satisfactory a level as they would like to provide as professionals. Research into WE is useful to consider in this context. *Absorption* is the third component of WE – the experience of full concentration and being engrossed in work (Bakker et al., 2011). Whilst staff are busy, as one person mentioned, being too busy can impair job satisfaction. Being too pressurised, having to rush through work, means that staff cannot fully experience the engrossment and 'flow' of full engagement. A member of staff working in mental health nursing notes the following, suggesting that he was too busy with routine tasks to do what he considered the important therapeutic aspects of his role:

M. So it's not about, you know, eh, the busy-ness side of things, you know. Being busy is okay. It's being stretched so that you can't be properly busy as it were [laughs].

Some other comments regarding paperwork are borne out in other studies. An RCN Poll (April 2013) found that more than one-sixth of the working week of nurses was taken up doing what was perceived to be non-essential paperwork.

One interviewee observed the tendency for staff in the NHS to 'grumble'. Hertzberg's (1966) hygiene factors may be a partial explanation here – staff take for granted the positive aspects of the work contract (this might include paid holidays, incremental pay scales etc). But this is to oversimplify. Some staff did mention positive aspects of the employment conditions. But it was also mentioned that the good aspects, for example family leave arrangements, could also cause guilt if one was leaving one's team understaffed, in a situation of no recruitment of temporary staff to cover for absence. Similarly, availability of online learning opportunities was tempered by the feeling that one could not undertake this in work time, because other staff might resent the fact that you were not doing your real work, 'tippy-tapping' on the computer. And the issue of administrative and support staff not being part of the commitment to 'no compulsory redundancies' clearly impacts upon a

significant section of the workforce, and forms an undercurrent of resentment and anxiety. These findings indicate that factors which impact on job satisfaction as a component of engagement are complex and contextual.

Engaged at the individual level: Commitment and EE

Commitment to the organization and its goals is a central aspect of the constructs of EE and WE. The term ‘commitment’ was referred to extensively by focus group participants and interviewees. Staff talked about commitment to patients, commitment to colleagues, commitment to the NHS and to their profession. As discussed, there is a long prior history of research into workplace commitment, and it is pertinent to draw on this wider body of literature to explore the findings of this study.

Meyer et al. (2004) distinguish between affective attachment to the organization, normative obligation to remain, and continuance commitment, the perceived cost of leaving. They suggest that affective commitment demonstrates the strongest positive correlation with job performance, OCB and attendance, followed by normative commitment. The findings from this study suggest that staff feel a lack of affective commitment to the organization. However there seems strong affective commitment to the patients, to the work itself, and to colleagues. This suggests that the notion of organizational commitment in the context of EE needs to be interpreted more broadly. An EE survey question on normative commitment (eg. asking if employees intend to say working in their current organization) will give a limited and possibly inaccurate indication of employees’ commitment to their work.

Meyer et al (2004) suggest that in normative commitment individuals perceive acceptance of goals through externally regulated obligation, rather than autonomously regulated, self-set goals perceived as ideals. One might contrast the ‘targets’ as externally regulated goals with ‘patient care’ as internally regulated ideals. Normative commitment develops through cultural and organizational socialization. So organizational processes to inculcate acceptance of, and compliance with targets might be successful in changing working practices. However they appear not to be successful in creating ‘engagement’ with these goals.

Bakker et al. (2011: 4–5), writing from a WE perspective, refer to employees who invest themselves fully in their job roles, ‘who are proactive and committed to high performance standards’. Clearly this is what NHS Lothian desires from staff, in the context of meeting

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targets for quality of care, and staff expressed commitment to high performance standards. However staff may have different interpretations of what these standards are. Interviewees (HRD professionals) were generally positive about performance targets, for example, whereas staff who participated in focus groups tended to be critical of them. Their perspective on quality service was that targets sometimes got in the way, were about other priorities, or were not supported by appropriate resources.

Robinson (2003) note five types of organizational commitment:

- Affiliative – compatible with organizations interests and values

- Associative – perception of belonging

- Moral – sense of mutual obligation

- Affective – job satisfaction

- Structural – fair economic exchange. (Robinson, 2003: 12)

Using these terms, staffs' affiliative commitment might be with the organization, but their associative commitment might be more with the team or ward. Their moral commitment comes from their professionalism.

Theorising organizational commitment in the manner of Meyer et al.'s (2004) and Robinson's (2003) work provides a more nuanced understanding than the rather generalised construct of EE. Bakker et al. (2011a) argue that theory on WE as a motivational construct conceptualises it in various way, for example as affective organizational commitment, as emotional attachment to the organization, and with respect to discretionary behaviour. To contribute to deeper understanding, the construct of EE would need to incorporate these different perspectives on commitment.

Summary : meanings, purposes, behaviours and attitudes attached to the concept of employee engagement in NHS Lothian.

Despite potential for confusion with staff governance, EE as a term has relevance within a health service context. The term encompasses a range of meanings and purposes, which stimulated diverse discussion amongst the research respondents. Engagement surveys will not capture the nuances of staff experience of engagement. Although EE means different things to different individuals and groups of staff, staffs' perceptions concurred with

definitions of engagement in the literature. Key issues emerged around engagement with the organization, the psychological contract, job satisfaction and commitment.

Whilst expressing distance from the organization and lack of engagement at the organizational level, staff describe feeling engaged with their work as professionals, especially when supported by colleagues. Thus it seems that staff can be both engaged with their work and express disengagement with some aspects at the same time. As Herzberg (1966) noted in his study of job enrichment, you can be satisfied with hygiene factors whilst dissatisfied with motivators. The findings indicate that engagement of the individual employee is mediated by factors other than *organizational* goals and values, in this case the goals of *patient care*. This points to limitations of engagement measurement tools which measure perceptions of engagement with organizational goals.

The concept of the psychological contract proved relevant to participants and useful to the analysis in this study, as it captures both explicit and implicit expectations of staff and employer. Research on job satisfaction was useful to frame an analysis of staff feelings and views on their work. Bakker et al.'s (2011) work on WE provided a relevant frame of analysis of how being too busy can detract from engagement in meaningful aspects of the work. Factors which impact on the experience of job satisfaction are complex and contextual, and again not fully reflected in the construct of EE. Similarly, work on organizational commitment provides an opportunity to develop a more nuanced understanding of staff experience. Staff feel a lack of affective commitment to the organization but an affective commitment to the patients. Organizational initiatives to stimulate normative commitment to goals such as compliance with targets will not result in EE as such but may result in desired behaviours.

RQ2. What factors act as drivers for and barriers to employee engagement in this setting?

Drivers for EE in NHS Lothian

In terms of drivers for engagement, staff in focus groups had an insight into this, and their comments seemed to concur with the research into EE. Engagement was seen to require a give and take relationship between employer and employee (Robinson et al., 2004). Drivers of engagement included such things as open communication; fair and equal treatment;

reasonable working hours; opportunities for training and development (eg. Macleod and Clarke, 2009; 4-Consulting, 2007). Interviewees commented on the importance of communication with staff and involvement. A number of drivers of EE focused on the contribution of L&D, and these are discussed in a later section.

A particular focus in EE literature is on the importance of taking an ‘engaging’ approach to management and leadership. ‘Engaging managers’ should facilitate and empower rather than control or restrict their staff; they should listen, provide feedback, and offer support and recognition for effort (Macleod and Clarke, 2009). Focus group staff recognised the role of supportive managers, and interviewees also recognised the importance of line managers in creating a climate for engagement, so the idea of ‘engaging managers’ seems to be borne out (Alimo-Metcalfe et al., 2008). In the interviews mention was made of encouraging ‘transformational’ approaches to leadership in NHS Lothian, which has been linked to behaviours associated with engagement, such as job satisfaction and organizational and team commitment (Mathieu et al., 2008). Coaching, also introduced into NHS Lothian, has been found to positively influence self-management, team-member relationship quality, member satisfaction, team empowerment and psychological safety (Mathieu et al., 2008), so this seems a relevant move given the significance of the team as a locus of engagement (to be discussed more fully later in this chapter). Interviewees recognised the need for ongoing management and leadership development to help managers to support staff through the significant organizational changes.

Drivers and barriers to EE are listed in Table 20 overleaf.

Drivers for engagement	Barriers to engagement
<p>Communication. Staff involvement. Give and take relationship between organization/manager and employee. Fairness. Supportive line managers. Good clinical supervision. Supportive work colleagues. A good team. Clear objectives. Recognition from managers. Recognition from patients. Seeing how your work contributes to the 'bigger picture'. Commitment to good patient care. Professional ethos. Commitment to the NHS. Opportunities for training and development. Good quality training. Opportunities to put learning into practice. Protected time for training/learning. Opportunities for sharing learning/ informal learning.</p>	<p>Constant heavy workloads. Expectations of organization are already high. No slack. Constant pressure, firefighting. High intensity work. Feeling exhausted. Pressure to meet targets. No cover for absent staff. Financial climate. Negative team members. Lack of recognition for effort. Lack of positive feedback. Managers stress impacts on their team. Tokenistic consultation. One-way communication, not being listened to. Lack of senior management understanding of the work being done. Job insecurity. Feeling unsafe. Lack of management support for staff development. Not able to attend training due to staff shortages. Too much mandatory training. Not being able to access relevant training. Formalization of informal learning /skills sharing. Reallocation of former work responsibilities from nurses to doctors. Lack of promotion opportunities. Competing management discourses. Personal circumstances.</p>

Table 20 Drivers for and barriers to employee engagement in NHS Lothian

Identification of drivers for engagement is inextricably linked to discussion on barriers to engagement, 'what gets in the way'. The following discussion on barriers to engagement is longer than this section on drivers, simply because the discussions in the focus groups touched on a wide range of barriers to engagement. However, 'barriers' are in many respects

the opposite of ‘drivers’; that is, the way that discussion on barriers to engagement developed suggests that the absence of the barrier would indicate a driver. Hertzberg (1966) found that the absence of a source of dissatisfaction does not indicate a source of satisfaction. However, in the focus group discussions staff were asked ‘what gets in the way of engagement?’ so barriers were discussed as part of identification of drivers of EE.

Barriers to EE in NHS Lothian

There were aspects of the work and the way it was organised that were cited as barriers to engagement. McBain (2007) identifies ‘drivers’ of engagement in ‘clusters’ – the organization, management and leadership, and ‘working life’, which were all mentioned by focus group staff. Interviewees had some interesting reflections on barriers to engagement, citing workloads and management styles as potential barriers.

Heavy workloads were a particular a barrier to engagement, as noted in this example of a focus group comment:

M I was just going to say that because there’s no slack in the system...I.. just see people right at the very edge of what they can deliver.

Staff felt that they were already ‘going the extra mile’ and this limited the capacity or willingness to put in more effort, as this illustrative quote shows:

F. I think I’m becoming less tolerant to the extra mile because of the, what we are having to do as daily bread and butter is extra isn’t it [laughs].

Macey and Schneider (2008) in a discussion of WE explore engagement as a *state*, incorporating affect, energy and passion. Fairlie (2011) and Bakker et al (2011) discuss staff who are engaged in their work as having high levels of energy and mental resilience (*vigour*) and *dedication*. Whilst staff in this research may express dedication, or a positive affect, many staff describe feeling exhausted, ‘*flogged every single day*’, at the edge, with not much more to give. This is illustrated by a focus group comment:

F. I see more people now who are on the cusp of saying ‘oh blow it, I’ve done as much as I can, I’m going’. Just on that cusp.

It seems that *vigour* and energy may be impacted by factors such as heavy workloads and long hours. Staff comment on feeling de-motivated because of the constant pressure and

having to operate at high intensity on a daily basis, and feeling that this effort was not really recognised.

These comments are borne out by a survey by the RCN (October 2011) which reported that ‘nurses working in Scotland’s NHS are under immense pressure as financial worries, stress and job insecurity push them to breaking point’. 74% reported increased stress at work. This seemed also to be echoed in the experiences of administrative and support staff, and of managers.

Whilst focus group staff expressed pride in their work, there was overall no sense of wellbeing, which is also argued as being important for EE. Robertson and Cooper (2010) differentiate between ‘Narrow Engagement’ which focuses mainly on commitment and citizenship, and may risk employee’s psychological health, and their concept of ‘Full Engagement, which pays equal attention to the wellbeing of individuals. This seems an important idea for NHS Lothian to incorporate into any initiatives to promote engagement.

There was some evidence of staff disengagement emerging from the focus group discussions. As defined by Kahn (1990: 694) personal disengagement is ‘the uncoupling of selves from work roles; in disengagement they will withdraw and defend themselves physically, cognitively, or emotionally during role performances’. Some staff said that they were reluctant to stay on and work extra hours, but there is no way of assessing from this study if their work quality is affected. But this seems at the very least a ‘precursor to disengagement’, and as claimed by Attridge (2009), employees who are disengaged can have a disproportionate impact on others in their team, which can serve to undermine more engaged co-workers. Robinson et al. (2007) comment on the cost of disengagement to the economy – but what is the impact on patient care in a healthcare setting?

In this respect one might note the current wide news coverage regarding deficiencies in patient care in NHS hospitals. Whilst there is no evidence of these problems in this research, clearly this is an issue that all healthcare organizations must be vigilant about, even if it reflects the behaviour of only a small proportion of the workforce.

There were some criticisms of managers, and there appears to be transactional rather than engaging leadership styles in some parts of the organization. Some managers were deemed

to be unsupportive of staff development. There some suggested explanations for these observations, where staff showed insights into the pressures on managers. Some staff recognised that their manager might become more ‘*bullish*’ or less available as a result of pressures in their own role. Staff noted the stress that managers were under, one noting that her manager ‘*works fifteen hours a day her Blackberry is with her constantly.*’ Managers’ stress impacted upon staff, for example administrative staff complaining about the volume of emails from their manager. Management layers were reduced but the same work needed to be done by fewer staff. This impacted on the motivation of administrative staff, as illustrated by the comment:

F I'm struggling to feel motivated cause I feel it doesn't matter what I do or how much I try to do there's always another pile of stuff that doesn't get done.

Managers are likely to be experiencing multiple and at time contradictory pressures. One might ask about the organization, are managers rewarded for achieving targets, or for being ‘engaging managers’? Bowles et al. (2012) note that where espoused organizational values are not manifested in leadership behaviours, this can give rise to a ‘cultural disconnect’ and impact on levels of engagement.

Various other factors which have been shown to impact on engagement were addressed by respondents. Performance feedback is cited as a driver of engagement in the literature, and some staff complained about the lack of positive feedback from managers. This may be an issue that is amenable to management development interventions. Alimo-Metcalfe et al’s. (2008) study in the NHS identified three dimensions of leadership culture to support engagement – engaging with others, visionary leadership, and leadership capabilities. These are all issues that are being addressed by NHS Lothian in various ways, but also significant challenges in such a large organization. They also suggest the need for clear systems, procedures and guidelines. This seems to be a feature of NHS Lothian – staff were all aware of the PDP requirements, for example, although some complained of the large numbers of procedures and guidelines.

There is evidence of some inappropriate behaviour by managers, and this also can act as a barrier to engagement. Staff complained about consultation being experienced as ‘tokenistic’. There was a sense that staff felt that communication tended to be one-way, rather than management listening to staff. Even important issues that were raised by staff,

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such as practice deemed to be risky, could be ignored. This was considered to be disempowering, as noted by a focus group participant:

F. People will get completely disengaged if they are not being listened to.

This feeling of not being listened to translated into expression of an organizational climate where there was a general reluctance to question and challenge poor practice, and some staff used words such as '*terrified*'. Whilst this might seem alarmingly strong language, a recent report by the UK Royal College of Nursing (BBC, April 2013) identified a 'culture of fear' in the NHS with respect to whistleblowing, so this is an issue not reserved for NHS Lothian, but the comments are significant as some staffs' experiences seem to replicate broader issues prevalent across the NHS.

Kahn (1990) discusses psychological conditions necessary for individual engagement: meaningfulness, safety and availability. Some staff describe feeling fearful for their jobs and unappreciated by managers, which would seem to be negative factors with respect to 'safety'.

Some studies have found different levels of engagement amongst staff in different roles. Due to the smaller number of administrative and support staff that participated in the focus groups, it is not really possible to conclude any substantial differences in experiences. One point that did emerge strongly was the issue of not being included in the 'no compulsory redundancies' promise, which could be impacting upon engagement.

Some barriers cited may be amenable to 'engagement initiatives'. However, some of the barriers cited may be more appropriately addressed by management development interventions to support the development of management skills. These would need to be accompanied by organizational support and recognition for a more 'engaging' style of management. From the perspective of staff in the focus groups, the way that the organization manages workload and staffing issues, and tackling targets, were issues of concern. The issues of 'communication' and 'listening' could be addressed at a number of levels by both line and senior management. Some barriers are indicative of deeper, structural and wider issues, and less easily addressed. One way of gaining further insights into these issues is through the examination of competing discourses.

Competing discourses – impact on engagement

Drivers and barriers to engagement are not always simple to identify – some things are revealed by this study to act as both a driver and a barrier, either at different times or to different people. Targets can be seen as NPM discourses to construct new identities for public sector workers, through regulatory regimes which act to shape social practices. Staff are all aware of the targets and there appears to be reluctant compliance. But staff also complain about pressures and problems in this compliance. There is resentment – they don't appear to 'own' the targets. Whilst they do appear to understand the wider political context, they still complain about the managers' role in enforcing targets. Managers' perspectives seem to be prioritized here, and there is evidence of asymmetrical relations of power. Staff express resentment that no matter how much you do, it is never enough.

There is suggestion of a 'self-regulation' discourse through 'disciplinary technologies' (Thomas and Davies 2005:686). Staff complain about the expectation to 'go the extra mile', but they do it anyway, bemoaning lack of recognition or appreciation. It is recognised that things were different '*before*', whereas now it is '*expected*' that you '*do that extra stuff*', it's now '*the norm*'. This raises questions about the notion of discretionary effort incorporated in the engagement construct. A question on the NHS staff survey asks 'I am happy to go the 'extra mile' at work when required', with a score of positive answers of 83% against a benchmark of 89% (2008 Survey). Do these answers mean that staff are 'happy' to go the extra mile, or do it anyway, as noted by the quotes above? Is it necessary for staff to feel positive to exhibit engagement, as perceived by the notion of discretionary effort? Conversely, does 'going the extra mile' demonstrate engagement, or simply compliance with a new work order?

Health care organizations have multiple stakeholders (Brignall and Modell, 2000). Staff experience a matrix of discourses, of which NPM is one (Thomas and Davies, 2005). Rather than the unitarist view espoused by the 'public image' of the organization, the organization is made up of multiple and at times competing discourses (Learmonth and Harding, 2004). A member of staff commented on the uneasy relationship between medics and 'management', suggesting that they are '*driven by different things*' '*money by managers and patient care by consultants*'

Some staff see the message from NPM practices as caricaturing 'management' as being only interested in money, despite messages around quality and service. Others use imagery from a different age to describe the organization, e.g. '*serving wenches*', '*upstairs downstairs*', '*backline staff*'.

Thus staff experience competing discourses and multiple professional narratives, which at times complement and at other times contradict one another (Doolin, 2003). There is evidence of contradictions in organizational culture (Davies et al. 2009). Staff complain of increased bureaucracy. Staff espouse a strong discourse of professional commitment, which at time is at odds with the NPM discourse. The organization is a 'site of struggle' (Fleming and Spicer, 2007). As noted in a focus group, there was a tension between loyalty to the organization, to the NHS, and to patients, and '*if you see patients being disadvantaged by service cuts then it's quite tough*'.

Summary : drivers for and barriers to employee engagement in NHS Lothian.

Factors cited as contributing to engagement include open, two-way communication; engaging leadership styles; career development and training (4-Consulting, 2007; Macleod and Clarke, 2009). Work colleagues can provide support acting as a driver of engagement (Bakker, Albrecht & Leiter, 2011). Management support was considered important.

Barriers to engagement included pressure to meet targets, the impact of financial and staff cutbacks, unsupportive management, and various individual circumstances. There was some evidence of a lack of the psychological condition of safety, important for EE (Kahn, 1990.). However management and leadership development initiatives in the organization may address some of these issues.

Evidence of disengagement included some reluctance to work extra hours. Disengagement may impact on the performance of other work colleagues. Workloads and targets contributed to reported feelings of stress. The high levels of energy and mental resilience (vigour) needed for engagement, as cited by Fairlie (2011) and Bakker et al (2011), appear to be impacted upon by this work environment. This suggests that staff perceive that not enough attention is being paid to the individual staff wellbeing (Robertson and Cooper. 2010). Messages from the organization can also be experienced as competing discourses.

It seems that the conditions which are argued to contribute to disengagement do not operate in a simple cause and effect manner, with some factors act as both drivers and barriers, mediated through individual perceptions and motivations. Thus staff can describe feeling a lack of engagement with the organization, but are driven by a professional and vocational commitment to provide patient care. Some aspects of 'engagement' might be more perceived as 'compliance'. Discourses can complement, compete with or contradict one another.

RQ3. What key learning and development themes contribute to employee engagement in this setting?

Learning and Development and EE in NHS Lothian

As noted in the review of literature, HRD processes and practices form a key part of practices claimed to facilitate engagement. An important role for L&D was recognized by interviewees as that of supporting the achievement of organizational goals and requirements, for example the link to the KSF. Interviewees considered that L&D could be a driver of engagement. Focus group staff reflected on their personal experience and perspectives on L&D. L&D was generally considered in a positive vein by focus group participants. Staff saw a link between L&D and EE, as in this example:

F. The programme comes with an intense learning package which is just amazing, it's fantastic..... it's a rolling programme of training. It's ensured that you put this into practice and you use it and you learn new skills.....

I Really and do you feel that's contributed to your engagement then?

F Absolutely.

Training, employee development and career development do seem to be factors that help employees feel valued and involved. Being encouraged to learn new skills, line management support for development, opportunities for training, assessment of training needs and time to engage in training all were seen as positive in respect of EE. Less formal development opportunities, such as secondments, coaching, multidisciplinary working and special projects were also suggested as contributors to EE (eg. Robinson et al., 2007). Most staff welcomed the PDPs, with some exceptions. Induction, support for professional development, skills development, and management development programmes were all seen as relevant. There were suggestions for further L&D activities which might contribute to engagement, such as job shadowing, and for supporting communities of practice. The importance of both line manager and senior management support for L&D was recognised, as in the following illustrative quote:

F. I do think that is, that definitely is something that makes people feel involved and empowered and increases their commitment is knowing that they are going to get supported to do training.

As noted, there are a lot of different learning initiatives in NHS Lothian, and where this works well these could contribute to engagement, but the experience varies throughout the organization. The organization clearly sees an important role for L&D, and staff development is embedded in policies and practices in line with the 'new NHS' (Davies and Nutley, 2000). The organization has a range of L&D practices which have been shown to support engagement, as noted in the literature review. This includes support for individual personal and professional development; support for staff to gain professional qualifications; skills development; management development programmes; induction programmes; professional development portfolios; coaching. Career development is cited as a factor which impacts on engagement (4-Consulting, 2007), and is recently cited as a priority for the organization. Other factors which have been shown to link to EE include performance review (Robinson et al., 2007), and the KSF and PDP initiatives fit into this.

Job rotation and secondments occur for some staff, but perhaps could be looked at for more staff. Some staff also seemed unclear as to how their work fitted in with the 'bigger picture', which Alimo-Metcalf et al. (2008) found was important for engagement. They found that support for adaptability, experimentation, learning and innovation contributed to engagement, but staff experience again seems mixed in this respect. Sheaff and Pilgrim's (2006) work on the learning organization in the NHS also mentions the notion of a learning culture which encompasses issues such as communities of learners; learning leadership dispersed throughout the organization; people being confident to have an open dialogue about multiple perspectives; ongoing collective transformation and self-government. The 'open systems thinking' and 'team learning', dispersed learning leadership and freedom for open dialogue required for a 'learning organization' (Sheaff and Pilgrim, 2006) seem to be evident in some areas in NHS Lothian, but lacking in others, which might encourage narrow, technical learning. Sambrook (2006) emphasizes the 'multiple discourses of HRD' in the NHS (2006: 49.) and highlights tensions between a focus on performance and the need to learn (Sambrook 2006: 26), all of which were evident in the findings. The comment in the interviews on the paradoxical relationship between learning and risk-taking merits further examination. The idea that failure is not allowed puts a barrier to risk taking, which is

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necessary for creativity and learning. It might be possible to envisage a more nuanced approach to risk which allows for more experimentation and potentially learning.

Staff talked about expectations around engaging in learning and development. Much of this was around the desire to have recognition and support for this activity. However there was considerable frustration expressed over the lack of career opportunities that might follow on from engaging in training and gaining qualifications. There was also resentment from some over the need to train in their own time, and the difficulty in getting back work time from doing overtime or training in ones own time. Some of the findings discussed above suggest that staff perceive that the organization is not meeting its side of the psychological contract with respect to L&D, as in the following illustrative quotes:

F. Whilst here everything seems to be on your own time. There's no money for courses. You struggle to even say get a day back.

Fas an organization I think probably nursing staff feel that they don't get very many opportunities to, to develop their skills and knowledge once they've finished University. They just get the mandatory ...stuff.

The range of issues of concern note by staff can be summarised:

Lack of time to attend training, lack of staff cover.

Reduced resources for training.

The main training that can be attended is mandatory training.

Perceived lack of relevance of mandatory training.

Dislike of online delivery (some).

Limited opportunities to participate in professional development training.

Lack of support for training from some managers.

Lack of recognition or reward for undertaking training.

Lack of opportunities to practice skills in the workplace.

Not all staff have had PDPs, and implementation of commitments under the Agenda for Change is an ongoing issue.

Some of these findings mirror those from the literature. Murphy et al (2006) found similar inhibitors to nurses undertaking CPD. McCabe and Garavan (2008) highlight the importance of leadership support for learning and development for nurses. Saks' (2006) model examines the antecedents and consequences of EE. Antecedents include job characteristics,

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rewards and recognition, perceived organization and supervisor support, and distributive and procedural justice, which were all themes that emerged in the discussion of the HRD perspective on EE. Saks also mentions the importance of distributive and procedural justice to EE, and this was raised in the context of access to L&D opportunities.

Interviewees noted that L&D faces significant challenges as a number of key developments, such as the KSF, were dependent upon L&D interventions, but these had to be managed in a time of cutbacks. There were challenges around implementing things such as PDPs for all. There is however a comprehensive framework to support L&D, both within the organization and via Scotland-wide organization such as NHS Education Scotland, educational institutions, and professional bodies. Mandatory training had a mixed reaction from focus group participants, but interviewees were unsurprisingly focused on how to ensure compliance and relevance of mandatory training. It was suggested that there is a need to improve evaluation of L&D.

Table 21 overleaf summarises the key L&D interventions and practices in NHS Lothian that have been linked to EE in this research. It suggests general and specific factors which serve to support these activities, and factors which inhibit these learning activities.

Table 21. L&D and Employee Engagement in NHS Lothian

L&D interventions & Practices	Specific supporters	Specific inhibitors	General supporters	General inhibitors
Training-generic, mandatory	Management recognises importance.	Topics seem not relevant. Online delivery not liked by all.	Supportive managers. Available courses. Staff cover for absence. Specialized training. Earmarked resources. Opportunities to practice.	Heavy workload. Lack of staff cover. Management support lacking. No dedicated time. No mgmt. recognition of learning. No clear reward. Limited resources for much professional training.
Training – individual	Dedicated resources. Available courses.	Lack of funding. Time taken up with mandatory training.		
CPD	KSF, PDP	PDPs not up to date.		
Informal learning	Team working. Stretch responsibilities.	Workload pressures. Removal of responsibilities.		
Experience sharing	Team members willing to share.	Formalization.		
Career Development	Projects, secondments, support.	Recruitment freeze.		
Researching practice	Support to engage in evaluation/ research. Simple administration.	Over formalization, demanding approval criteria.		
PDP	Managers committed to PDP	Lack of management support.		
IIP	Framework, training for assessors.	Cynicism.		

Summary: key learning and development themes which contribute to employee engagement in NHS Lothian

A range of L&D interventions and opportunities were cited as contributing to engagement, both formal and informal, in line with other findings in the literature. General supporters for L&D included management support and recognition, relevant learning opportunities,

available time and appropriate resourcing, and opportunities to apply learning in the workplace. Absence or limited management support, heavy workloads, lack of resources, lack of dedicated time and recognition for learning could act as inhibitors to L&D. A range of contextual L&D interventions and practices were noted, and specific supporters and inhibitors identified.

As noted earlier, there is not a simple cause and effect relationship between engagement and L&D – both individual and organizational contextual factors contribute an impact. Staff must perceive the learning opportunities as relevant. There were mixed views on the mandatory training, for example – some recognized it as relevant, others as a necessary chore, and others saw it mostly as a waste of time. Protected time for learning is important, ideally away from the workplace. Even so, heavy workloads and long hours mean less time and energy to engage in L&D. This can lead to resentment if it only results in attendance to mandatory training, excluding other training of specific relevance to individual goals and aspirations.

Individual staff vary in their motivation for learning. Some staff are willing to engage in L&D in their own time, if they see a reward such as career progression. However a lack of opportunities for promotion or career progression can act as a barrier to engaging in L&D. Managers need to provide recognition for staff's efforts in engaging in L&D. There needs to be opportunities to put the learning into practice in the workplace.

Regarding strategic HRD themes (e.g. Boaden et al. 2008), personal development planning is broadly accepted, but the qualifications above apply in this broader context. Management development interventions seem to be aligned with organizational goals.

RQ4. How can we conceptualize employee engagement within a health service context?

Conceptualising employee engagement

Some of the findings are contextual, the empirical work being based on a specific organizational case study, although the literature consulted is not restricted to this context. The preceding discussion on the first three research questions provides insights into how to conceptualize EE within this context. As regards the construct of engagement, the findings

generally concurred with literature on engagement. Particular issues for this study were that staff did not feel engaged with the organization, but more with their day-to-day work and with their patients. The psychological contract, job satisfaction, and commitment were important factors in considering engagement. Findings on drivers and barriers to engagement generally concurred with other findings in the literature, and specific contextual drivers and barriers were revealed. L&D interventions and practices were seen to contribute to engagement, and supporters and inhibitors of L&D and engagement identified.

Where the findings concur with other findings in the literature, wider theoretical generalization is possible. Some generalizations may be specifically relevant to the health sector, but potentially some findings may be of relevance to the wider management and HRD research community. This section will draw out and seek to theorize some broader conceptualizations of EE that have emerged from this study.

Locus of engagement

The findings illustrate that engagement with ‘the organization’ is only one of several loci of engagement. As Chalofsky and Krishna (2009) argue, contextual and organizational factors impact upon an individual’s motivation (and hence their engagement). Focus group staff recognised the supportive role of work colleagues, which seemed to be a major driver of engagement. The positive impact of ‘job resources’ such as social support from colleagues, skill variety, opportunities to learn and to develop, and performance feedback (Bakker et al., 2011a), were all mentioned. Interviewees also noted that staff would be more likely to be engaged at the level of their job or team. In this respect the notion of ‘locus of engagement’ is upheld by the focus group findings.

Much literature on EE is based on the relationship between the individual and the organization as the prime ‘locus’ of engagement, and emphasises that individual engagement comes when a member of staff is driven by organizational goals. The organization provides support to the individual staff member to facilitate engagement. However the findings from this study are that engagement is stimulated by, mediated, facilitated and supported from a number of other loci. Staff did not identify with phrases such as ‘commitment to their board’ (in the NHS staff survey), as illustrated by the following comment from a focus group:

I don't feel I, I'm NHS Lothian, you know.

Commitment is to patients and colleagues. Engagement and motivation was seen to come from giving a satisfactory service to patients, as illustrated:

F. We know ourselves if we are satisfied with the service we give our patients, that's certainly us being engaged and being motivated.

The different potential loci of engagement identified in this study were:

The profession

The NHS

NHS Lothian

Customers, clients or patients

The department or business unit (ward),

The work group or team.

Figure 6 indicates these different loci of engagement in diagram form.



Figure 6. Loci of Engagement in NHS Lothian Diagram

Loci of engagement diagram explained.

The NHS. NHS Lothian is situated within the broader context of the UK NHS. Staff seemed particularly driven by an allegiance to the values and goals of the NHS.

The profession. Most of the staff who participated in the study were professionals who have an allegiance to their wider profession. As Wallace (1995) notes, professionals adapt their professional ideology to incorporate the ideals and goals of the employing organization.

Customers, clients, patients. Patients were frequently cited as a main driver of engagement, concurring with the findings of Meyer et al. (2004) that commitment may also be to a profession or to customers and clients.

Department or business unit. Staff in focus groups tended to identify more with their department or ward than with the wider organization.

Work group or team. One significant finding in this study is that a particular driver of engagement were immediate colleagues in their team.

It is suggested that the strength of engagement with the various loci will vary for different individuals and in different work environments. The model incorporates a posited dimension of overall strength of loci for staff in NHS Lothian, based on the findings from the study. These are listed as positive (+ve), neutral (=), and negative (-ve). These are findings that were emphasised in this qualitative study, not statistically tested trends or relationships.

The figure illustrates that particularly positive loci for engagement were the NHS, patients, and the work group or team. The profession and the department or ward were less strong loci. However the organization was not seen as a locus for engagement and in fact tended to have a negative impact on engagement. The team as a predominant locus of engagement will now be examined further.

Locus of engagement with the team

As Latham (2007) notes, team members experience ‘social identification’ with their team, especially smaller work groups. This study found that whilst some individuals espoused a lack of engagement with organization-level priorities, they demonstrated engagement

particularly at the level of the team. Whilst the wider locus of engagement considerations in the above model operate, the team or work groups appears to be a particularly significant locus of engagement for the staff in NHS Lothian who participated in the focus groups. This suggests that more attention should be paid to the role of the team and work group as a contributor to engagement.

As discussed in the review of literature, whilst there has not been much focus on teams and EE, there has been extensive research on motivation and commitment in work groups and teams. Meyer et al.'s (2004) notion of 'commitment to social foci' suggests that individuals' commitment may be mediated through their experience of team working. The team or work group can be a prime target of commitment (Meyer et al., 2004), through processes of 'social identification' (Latham, 2007), and an important source of organizational support (Bishop et al., 2000). This study supported the contention that the team can serve as a 'driver' of engagement, illustrated by the following focus group comments:

F1 Hmmm, happy to go the extra mile, I mean...

F2 Yeah and everybody does I think.

F1 I mean everybody still does because like I say it's the loyalty to the colleagues

This is not an aspect that currently features predominantly in influential models of engagement. Macey and Schneider's (2008) 'Framework for understanding the elements of employee engagement (see Figure 4) highlights the contribution of work attributes, variety, challenge and autonomy, and emphasises the importance of transformational leadership as a contributors to engagement, but does not mention teams. Baker and Demerouti's (2008) JD-R model of work engagement (Figure 5) includes 'Social Support' from colleagues within the category of 'Job Resources', which does recognise this important aspect, but as one of a list of job resources. Most suggestions for external support for engagement focus on the role of managers and leaders, eg. Alimo-Metcalfe et al. (2008).

Kahn's influential (1990) model of the 'psychological conditions of personal engagement and disengagement at work' (Table 7) highlights three necessary conditions of meaningfulness, availability and safety. Experiential components of meaningfulness include 'feel able to give and receive from others in the course of work'. Influences include 'work interactions: interpersonal interactions with more or less promotion of dignity, self-appreciation, sense of value, and the inclusion of personal as well as professional elements'. Fairlie (2011) also cites meaningful work is cited as a contributor to engagement.

Other parts of Kahn's (1990) model mention the significance of interpersonal relationships which offer support, trust, openness, flexibility and lack of threat, and the contribution of group and intergroup dynamics providing space for the expression of self. These all have resonance with the comments made by focus group participants about the importance of their work group and colleagues. Indicative comments were related to not wanting to let colleagues down, e.g.:

F1 There's commitment to your colleagues... colleagues are faithful to each other.. and have a degree of loyalty

Support from the organization and support from the team may both impact on employee commitment in different ways. There is evidence that normative commitment is developed (Meyer et al., 2004) at both the team and the organizational level.

A group can also be considered a community of practice, in which members construct meaning when they interact with one another in working life, and with technologies and tasks, and learning emerges from social interactions (Molbjerg Jorgensen, 2011: 110). Hatch and Yanow (2003: 68) comment on the process of sharing tacit knowledge and creating intersubjective understanding within a 'community of meaning'. As one focus group participant notes:

F. It's sort of continual learning from one another.

Literature has already established the team as a source of commitment and motivation, and a locus for learning. Linked with the findings from this study this suggests a role for the team as a locus of engagement. The differing theoretical perspectives on the team examined in the review of literature review are linked with the findings of the study in the following Table 22. This draws together aspects of team learning and support and places these in the context of EE.

Key themes in literature	Issues emerging from data	Example quotes
Engagement & Team Team as locus of engagement (CIPD 2011)	Feeling engaged with co-workers or the team. Colleagues as a driver of engagement.	<i>Definitely at team level rather than even at managerial level</i>
Commitment & Team Commitment to social foci (Meyer et al 2004) Perceived team support (Bishop et al 2000) Social support from colleagues (Bakker & Demerouti 2008) Team motivation, social identification (Latham 2007) Community of meaning (Hatch & Yanow 2003) Interpersonal interactions (Kahn 1990) Meaningfulness (Kirkman and Rosen (1999; Kahn 1990; Chalofsky & Krishna 2009) Impact of context on workplace motivation (Chalofsky & Krishna 2009)	Loyalty to colleagues Commitment to colleagues and the team. Colleagues provide support. Feeling a bond with colleagues. Colleagues as motivator for discretionary behaviour, eg. stay on late at work to help them. Mutual appreciation of work of team members. Team members have a shared sense of humour. Having a good team to work with.	<i>And it is about the local connection and how we're valued as workers by those around us.</i> <i>It's how they feel that they fit into the team.</i> <i>Your commitment is to your colleagues.</i> <i>You don't want to be seen to let your colleagues down.</i> <i>And have a degree of loyalty.</i> <i>Not to the organization but to the department and their colleagues. because colleagues are faithful to each other.</i>
Learning & Team Team learning (Sheaff & Pilgrim, 2006) Shared leadership (Mathieu et al 2008) Communities of practice and learning, sharing tacit knowledge (Molbjerg Jorgensen 2011; Hatch & Yanow 2003)	Informal learning, skills and knowledge sharing. Shared learning. Informal and formal coaching - experienced staff pass on knowledge and skills to newer staff, sometimes informally and sometimes as part of a peer supervision responsibility. Staff who went on training courses cascade their learning on to colleagues.	<i>It's sort of continual learning from one another.</i> <i>So there's a real opportunity there for shared learning</i>

Table 22. The team as locus of engagement, commitment and learning.

The findings on locus of engagement in this study have significance for the idea of supporting staff to engage in learning in teams and work groups. This could range from formal interventions, to less formal support to enable sharing of practice, and coaching, for example. Where it is problematic to remove whole work teams from the workplace for training, work-based learning and online learning opportunities could be further supported.

In the light of the significance of the team as a locus of engagement, and the importance of engaging leadership to EE, we can consider the issue of team leadership. Mention has been made of ‘shared leadership’ (Mathieu et al., 2008: 450), ‘empowering leadership’ (Srivastava, Bartol and Locke, 2006), and team empowerment (Kirkman and Rosen, 1999). ‘Empowering leaders’ delegate responsibility, seek input into decision-making, encourage team goal-setting and self-evaluation (Kirkman and Rosen, 1999: 60). This could also form more a focus in discussion on ‘engaging’ leadership and management.

The impact of Context on EE - NHS Lothian and the healthcare workplace.

The current NHS context is one of change and uncertainty; ‘modernization’ has brought new structures and operating arrangements, a focus on performance, culture management and external monitoring (Davies and Nutley, 2000; Sambrook 2001). Public sector organizations are charged with cost reduction and with the provision of more customer-focused services (CIPD/PPMA 2012). Preceding sections of this discussion and the findings have repeatedly touched on the impact of this context on staff engagement. In this study, context has emerged as a specific factor impacting on engagement in NHS Lothian, one which may have significance for the study of EE in other healthcare organizations.

In this study, engagement was seen to be experienced differently by staff depending on the type of job they were engaged in. Different staff within the same organization had different experiences of engagement. An individual member of staff could experience different levels of engagement when moving into different roles within the organization. There was frequent reference in focus groups to the impact of the work context of staffing reductions and increasing workloads upon staffs’ experiences of engagement.

Interviewees commented on the challenges associated with managing in the NHS, the impact of the broader policy and political context, and the need to balance demands from different stakeholders. It was recognized that there was an almost constant processes of change, which

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was challenging. Interviewees also commented that the overall climate of financial stringency and cuts was impacting upon all staff, and presented significant challenges.

It would seem that context has an important impact upon engagement and one that needs to be considered. Figure 7 presents the multiple contexts of engagement in NHS Lothian in diagrammatic form.

Figure 7. Contextual influences on Engagement in NHS Lothian Diagram



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The impact of multiple contexts on engagement in NHS Lothian – the model explained.

The organization: Goals, Structure, Policies, Finances, Staffing, Culture.

Much writing on EE sets the organization as central. In much discussion of engagement it is these areas that organizations are urged to pay attention to. The aim of EE for staff to feel committed to organization goals is mediated through the particular structures and policies of the organization. In NHS Lothian, particular issues are experienced around the financial stringencies and impacts upon staffing levels, career progression etc. Culture in all its manifestations serves to reinforce or impede the experience of engagement.

The NHS: Politics, Funding, Targets, Visibility.

But as comes through clearly in the literature and fieldwork, one cannot consider an NHS organization in isolation from the politics and policies of the wider NHS. This forms a significant aspect of the broader context, which in turn has an impact on EE.

Work group or team: Relationship with colleagues, Staffing levels, Sub-culture.

The importance of the work group or team to engagement has already been emphasized. Issues such as relationships with colleagues take place against the backdrop of the wider context.

Manager: Management style, Availability, Support for L&D & career development.

EE literature emphasizes the importance of the ‘engaging manager’. Management styles and approaches take place within the overall context, and also influence this context.

The job: Work processes, Routines, QA requirements, Controls, Flexibility, Autonomy, Workload.

The requirements and organization of the particular job impact upon engagement.

L&D: Training & development, Mandatory training, Informal learning, Knowledge sharing, Resourcing.

The contribution of HRD to EE has been emphasized. Again this cannot be seen in isolation from the particular context.

Patients/clients/customers.

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The customers, in this organization mainly the patients, are central to the context of the organization. For professionals in a health service context, patient care seems to be a key driver of engagement.

***Individual:** Career stage, Career aspirations, Experience, Job/person fit, Health, Family, circumstances.*

Each member of staff is an individual and their engagement will be mediated by their particular experiences and aspirations at any time.

The model does not propose any hierarchy of factors – experience is different for different individual and in different organizations and work environments.

Understanding employee engagement from an employee perspective provides insights into the complexity of engagement

As noted, literature on EE tends to centralize the perspective of the organization and the goals of management. A critical process of management study problematizes the dominant representations of the ‘reality’ of EE to offer alternative readings (Alvesson and Willmott 2012). This study has taken a social constructionist approach to draw out perspectives from employees, which has illustrated some of the complexities of EE. The study has sought to understand how staff experience their day to day work, the meanings and purposes attributed to EE, how they perceive the factors which promote or prevent engagement, and the contribution of L&D to EE. In all these aspects staff have contributed multiple insights into the complexity of engagement in this particular work setting. It is likely that some of the findings will have resonance with others working in an NHS setting, and possibly other healthcare and organizational settings.

Staff provided reflections on the construct of EE and its relevance for the health sector. The findings around locus of engagement and the importance of the team as a locus of engagement, as well as the significance of context to engagement, were all illustrated. There were illustrations of drivers and barriers to engagement, perceptions of the impact of L&D on engagement, and factors which act as supporters and inhibitors. Some particular insights have emerged from the personal descriptions of the experience of being engaged or disengaged, and what contributes to this. Staff may not feel engaged with the ‘organization’, but they are still engaged with their day-to-day work. A key ‘driver’ of engagement is patient

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care, and the professional commitments of staff. Staff seem more engaged as *professionals* than as *employees*.

Staff describe elements of being engaged and disengaged at the same time - disengaged with some aspects of the work, such as a reluctance to work extra hours, but still engaged with patient care. There were vivid descriptions of staff working *at the edge* – still engaged with patient care, but expressing concern for themselves and others over how long this can continue within the current work environment. The impact of *busy-ness* on the actual experience of EE, and on job satisfaction, provided illustrations of the complexity of engagement. There are some suggestions that engagement can at times be implicit rather than explicit.

Staff also commented on how stress impacted on the behaviour of their managers, and how this is experienced ‘down the line’. Strength of feeling was revealed, and words such as ‘terrified’ and ‘fear’ reveal the depth of staff’s experiences of the work environment.

Contrasting perspectives emerged in some places between interviewees (HRD professionals) and focus group participants (nurses, allied health professionals and administrative staff). Targets, for example, provided a particular backdrop to the work context of the organization. Interviewees recognized that there were big challenges around efficiency and change, and the need to communicate targets in meaningful ways. It seems that focus group staff, whilst aware of the targets, are working towards compliance more from a sense of coercion than one of engagement. Staff seem to be aware that meeting targets is necessary for the organization, but do not seem to *own* them - they are seen to be externally imposed by government and reinforced by management. There seems to be no sense of pride when targets are met.

EE is seen as a discursive construction, and one that is being embedded into thinking about NHS management practices. As Brignall and Modell (2000) argue, health care organizational environments are characterized by uncertainty, ambiguity and tension. When EE is viewed as a social construction, multiple and at time competing discourses operate in the work environment of NHS Lothian. Discourses of NPM such as targets vie with professional discourses of patient care.

Summary - conceptualizing employee engagement within a health service context

In some respects this whole study has been exploring how to conceptualize EE within a health service context. The discussions on research questions 1-3 present insights on the experience of EE as a construct within the organizational context, informed by the wider literature. The discussion on this fourth research question developed some new themes that emerged in the study. The emergence of insights in the analysis of the empirical work led into the discussion of the significance of locus of engagement, and the construction of an explanatory diagram. The notion of the team as a particular locus of engagement has been developed with reference to research into commitment and teams, and teams as a locus for learning, linking this to the context of L&D and EE. The discussion on the important impact of context on individual engagement has been developed and a conceptual diagram presented. This has been followed by reflections upon the insights gained into the complexity of EE and the need for a nuanced understanding.

Conclusions

This chapter has drawn out key themes emerging from the fieldwork, and what insights these provide in addressing the research questions for the study. A number of key findings have emerged, which are examined in the light of the review of literature. Some findings are discussed as having particular relevance to NHS Lothian. It is argued that some findings have relevance to other healthcare organizations and possibly also to organizations in other sectors. The next section draws together the conclusions for the study.

Chapter 8 Conclusions

Introduction

What has been learned from this inquiry and why is it worth knowing (Silverman 2005)? It is advisable to be circumspect in making claims about any topic of inquiry, taking the pragmatic position of ‘warranted assertability’ (Dewey, 1938), which asserts that the goal of argumentation is to produce a well-reasoned judgment (Koschmann, 2003). Bearing in mind the limitations to generalization from a qualitative case study, some theoretical generalization is possible, in particular with reference to the extant literature. It is proposed that a number of findings may have wider implications beyond the case organization, throwing some light on the experience of EE from a staff perspective, and within the health service context, and raising some questions about the construct of EE. This chapter summarizes the key findings and overall conclusions from the study, and its potential contribution to knowledge in this field. It makes some suggestions for a future research agenda for the topic of inquiry, and reflects on some limitations of the study.

Key findings from the study

The first three research questions were focused on the context of NHS Lothian, and the fourth research question sought to reflect on the conceptualisation of EE within the wider healthcare and organizational context. The key findings are now summarized in the order of the research questions. As discussed, theoretical generalization or challenges to theory may emerge from the more specific context of the case study findings.

RQ1. What meanings, purposes, attitudes and behaviours are attached to the concept of employee engagement in a given health service setting?

The construct of EE has relevance to the health service context, although the term itself has not been widely adopted to date, and in the Scottish NHS context of this study the term EE has some potential for confusion with staff governance. Focus group respondents recognized the component aspects of EE, and could see its relevance for the health sector. The notion of EE stimulated deep and diverse discussion amongst focus group participants and in interviews, and broadly matched definitions of engagement in the literature. Engagement

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was seen to be multidimensional and complex, and may differ for different groups of staff. There were shared perceptions by staff that it could contribute to patient care, which was also the aspect of work with which staff seemed to be most engaged. Many of the perceptions on EE drivers, barriers and associated behaviours echoed findings in the literature.

A notable finding from the focus groups was that staff expressed feelings of distance from the organization and described a lack of engagement at the organizational level. Also notable was how they described feeling engaged with their work as professionals, and the importance of support from colleagues. A conclusion is that staff can be both engaged with their work and express disengagement with some aspects at the same time. The engagement of the individual employee is mediated by factors other than *organizational* goals and values, in this case the goals of *patient care* and their commitment as *professionals*. Accordingly common measures of EE that solely focus on organizational goals, will not capture the full range of how staff experience engagement. Organizational commitment, a term compared and contrasted with EE, was found to be a more nuanced construct than that usually incorporated in engagement models and measures, and one that is more widely adopted by staff. Staff can experience an affective commitment to the patients, but lack such affective commitment to the organization. Organizational initiatives to stimulate normative commitment to goals, such as compliance with targets, may result in desired behaviours, but will not necessarily result in engagement.

The findings also highlighted the importance to staff of being engaged in meaningful work. Work on job satisfaction, a concept that was widely recognised by staff, helped frame an analysis of staff feelings and views on their work, informed by research on WE. The concept of the psychological contract also informs this analysis, as it captures both explicit and implicit expectations of staff and employer. Being too 'busy' and pressurised can mean that staff do not experience the engrossment and flow of full engagement, which can detract from the experience of meaning in their work, and hence engagement. Individuals' experience of job satisfaction is impacted by contextual factors, and the construct of EE does not fully reflect these.

Staff described being mostly engaged in aspects of their work demonstrably contributing to patient care, but felt that some organizational and management practices interfered with their

engagement, and were more of a hindrance than a stimulus to engagement. The profession and support from team members seemed to be more of a specific contributor to engagement than the goals, policies and practices of the wider organization NHS Lothian.

RQ 2. What factors act as drivers for and barriers to employee engagement in this setting?

Comments of staff in focus groups seemed to concur with the research into EE in identifying drivers for engagement. Engagement was seen as a two-way relationship between employer and employee. Factors which could contribute to engagement include such HRD-relevant aspects as open, two-way communication; engaging leadership styles; career development and training; coaching and mentoring. The supportive role of work colleagues was highlighted as a driver of engagement, as was the role of ‘engaging managers’.

A variety of barriers to engagement were identified, many of which concurred with findings from the literature, and some which were context-specific (Table 20). Pressure to meet targets within a context of financial and staff cutbacks, lack of management support, and individual circumstances were cited as barriers to engagement, as were transactional leadership and management styles. Some staff felt there was a climate of fear, which indicates some lack of the psychological condition of safety, important for EE. This resulted in a reluctance to question or comment. However it was also noted that there are on-going management and leadership development initiatives in the organization.

Staff expressed elements of disengagement, such as a reluctance to work extra hours, which was frequently required of them. Whilst the study could not assess the impact of staff perceptions on actual work performance, the literature highlights the impact of disengagement on the performance of staff and their work colleagues. There was a particular focus on staff experiencing heavy workloads and pressures to meet targets along with reduced staffing levels and financial cutbacks, resulting in feelings of stress. The work context seems to impede the high levels of energy and mental resilience (vigour) needed for engagement, although dedication did not seem to be affected. Staff perceive that the organization is not paying enough attention to individual staff wellbeing, and there seems to be a focus on narrow engagement rather than full engagement.

The complexity of engagement has been noted in the previous section, and this can equally be applied to the construct of ‘disengagement’. It seems that the conditions which are argued to contribute to disengagement do not automatically lead to disengagement in a simple cause and effect manner. Some factors can act as both drivers and barriers. Barriers to engagement are also mediated through individual perceptions and motivations. Thus staff can describe feeling under pressure and lacking in engagement with the organization, whilst at the same time being driven by a professional and vocational commitment to provide patient care. They also experience competing discourses – the messages from the organization are complex and sometimes experienced as contradictory. The notion of discretionary effort as an indicator of engagement is questioned – is ‘going the extra mile’ conceptualized as compliance with a new work order of NPM through self-regulation rather than as evidence of engagement?

The organization needs to ‘practice engagement’ as well as just ‘speak engagement’. For example, if the organization thinks it is important for managers to act as ‘engaging managers’, then it needs to consider further how to support and also reward appropriate management behaviours. It is also necessary to consider how far the organization can expect staff to increase engagement in times of financial stringency.

RQ3. What key learning and development themes contribute to employee engagement in this setting?

L&D does seem to contribute to EE in NHS Lothian. The findings in the literature review suggest that opportunities for formal and informal learning are integral to EE, and this was also borne out in the fieldwork. Staff generally felt enthusiastic about opportunities to engage in training, and sharing knowledge and experience. L&D interventions which contribute to EE, and general and specific supporters and inhibitors to L&D and EE were identified (Table 21). Being encouraged to learn new skills, opportunities for training, assessment of training needs, and time to engage in training were seen as positive in respect of EE, as were less formal development opportunities, such as secondments, coaching, multidisciplinary working and special projects. A range of general supporters served to enable L&D to contribute to engagement – supportive managers, appropriate opportunities, organizational support, and opportunities to apply learning in the workplace. Absence or

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limited management support, heavy workloads, lack of resources, lack of dedicated time and recognition for learning could act as inhibitors to L&D.

Whilst there is evidence that L&D can contribute to EE, a number of barriers emerged, both general and specific to the context. Concerns over L&D included: issues around time and resources; relevance of training; dislike of online delivery; lack of opportunities for professional development; lack of support from managers; lack of recognition or reward for undertaking training; and lack of opportunities to practice skills in the workplace.

Experience of personal development planning is mixed.

The impact of L&D on engagement is mediated through both individual and contextual factors. The learning opportunities must be perceived as relevant by the member of staff, and there needs to be management support and recognition, opportunities to practice new skills, and opportunities for career development. There needs to be protected time for learning, preferably away from the workplace. Workloads and long working hours mean impact upon engagement in L&D. If training time and resources are taken up with mandatory training, leaving no time for other training of specific relevance to individual goals and aspirations, this can lead to resentment.

Individuals varied in motivation for learning, depending upon factors such as potential career progression, and this impacted upon willingness to engage in L&D in staffs' own time. Lack of opportunities for promotion or career progression due to the current financial climate can act as a barrier to the engaging role of L&D. Some people need recognition from management for their efforts in engaging in L&D.

RQ4. How can we conceptualize employee engagement within a health service context?

Conceptualising employee engagement

The findings discussed under first three research questions contribute to the conceptualisation of EE. Staff concurred with the overall definition and scope of EE as described in the literature, and felt that it was relevant to the health service context. Staff feel more engaged with their day-to-day work and with patients than with the organization. The importance of the psychological contract, job satisfaction and commitment has been

discussed. Drivers and barriers both general and contextual were identified, and the contribution of L&D to engagement. The fourth research question provided an opportunity to develop a further analysis of several significant themes that emerged.

Locus of engagement is more than just with the organization

The main assumption of much writing on EE is that individual engagement is focused on organizational goals, and that engagement can be stimulated by organizational commitments, practices and interventions. Some models suggest that relationships with colleagues and others can play a part in stimulating engagement, but not as a central factor. This study identified that staff can have a range of ‘loci’ for engagement, which could include: the profession; the NHS; NHS Lothian; customers, clients or patients; the department or business unit (ward); and/or the work group or team. A conceptual model for individual loci of engagement in NHS Lothian is proposed (Figure 6). This hypothetical model suggests that for an individual employee there can be several possible loci for engagement. Not all of these might apply in any case; equally several could apply for any one individual, and will vary across different work environments. This study found that for staff in NHS Lothian the team or work group was a particularly strong locus of engagement, along with patients, and the wider ideal of the NHS. There seemed to be a sort of disengaging effect associated with NHS Lothian. This model could be adopted for further research in other contexts.

The work group or team is a particular locus for engagement, commitment and learning.

The study found that the team or work group can serve as a ‘driver’ of engagement and can be viewed as being a prime ‘locus of engagement’ (Table 22). Staff members feel more engaged with their direct colleagues than with the wider organization, and find meaning located at the level of the group or team, although some common commitments are shared between staff and organization. This draws on research on motivation, commitment and learning in teams, which suggest that staff find meaning located at the level of the group or team. Staff may express a lack of engagement with the wider organization at the same time as feeling engaged with their local group of work colleagues in the ward or unit. This locus of engagement at the level of the team does not receive as much emphasis as the organizational locus in current models of EE or WE, although some such as Kahn’s (1990) model provide for an interpretation of the importance of this locus. The team can also serve

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as a focus for learning, emphasising the link between L&D and EE and echoing research on team learning in communities of practice, for example.

Work and organizational context has an important impact upon engagement.

EE is often argued to be a ‘one size fits all’ construct, applicable across different types of job or workplace, and experienced similarly by different individuals. This study found that staff within the organization had different experiences of engagement. A member of staff moving into different roles within the organization could experience engagement differently. The organizational context of targets, recruitment freezes and increased workloads impacted upon staffs’ experiences of engagement. The different jobs, work groups and management styles which exist within the same organization provide different influences regarding engagement. Clinical and support staff share a commitment to patient care but their work experience differs in significant terms in respect of EE. In the health service the wider public sector context also impacts on the experience of engagement. It is argued in this study that work and organizational context has an important impact upon engagement, one that may not be sufficiently incorporated into current models of engagement. A conceptual model of the contexts of engagement upon staff in NHS Lothian is developed, incorporating 8 different components of context – the organization; the NHS; the work group or team; line managers; the job; learning and development; patients, clients or customers; individual factors (Figure 7). This model could be tested in other NHS organizations, and with some adaption could be adopted for further research in other organizational contexts. This would need to take account of the particular business sector, and the political and policy contexts.

Understanding employee engagement from an individual perspective provides insights into the complexity of engagement

The perspective of the organization or its management tends to be the main focus of much discussion and practice of EE, implicitly or explicitly favouring the interests of the organization over those of the individual employee. This study provides insights into the complexity of engagement by focusing on the perspectives of employees and their daily experience of the work environment. Staff comments contributed to the insights discussed in this chapter, such as locus of engagement, the impact of context, drivers and barriers, and the contribution of L&D to engagement. The suggestion that staff can experience both engagement and disengagement at the same time, and the impact of busy workloads on the experience of meaningful work provide insights into the nuances of the experience of

engagement. Difficulties in distinguishing engagement from compliance were revealed by the discussion on targets. One can observe multiple and competing discourses of EE operating in the work environment of NHS Lothian. From a critical perspective one must be alert to the application of management practices that purport to promote better staff experience, but do nothing to challenge the underpinning organizational structures and rationales, which may be oppressive, exploitative, or contradictory. In the context of the health sector, in particular in the public sector NHS, EE cannot be viewed without also taking in to account the aims and impacts of NPM.

Summary of conclusions.

The concept of EE is being increasingly used in the health service context, and in terms of practice and approaches there are substantial similarities between the application of EE in the health service sector and other sectors. However there remain considerable areas of debate over EE as a construct. The various models of EE examined in the review of literature indicate EE as a complex and contested area of study, and the findings of this study reveal layers of complexity around the construct as applied to NHS Lothian. EE encompasses a range of meanings and purposes, and there is a danger of the construct being interpreted in an overly simplistic manner which fails to represent the complexity of staff experience. Research about related constructs such as motivation, organizational commitment, job satisfaction, OCB and the psychological contract still have much to contribute to the engagement debate.

Several key findings emerge from this study. Staff can be both engaged with their work and express disengagement with some aspects at the same time, challenging the organizational focus of common measures of EE. Organizational initiatives may stimulate normative commitment to goals, which results in compliance and desired behaviours, but will not necessarily result in engagement. Staff need to feel engaged in meaningful work. The work context in NHS Lothian has an impact upon the levels of energy and mental resilience needed for engagement, although staff dedication is not affected.

Drivers for and barriers to engagement are both general and contextual, and do not operate in a simple cause and effect manner; and some factors can act as both drivers and barriers.

L&D does contribute to EE in NHS Lothian, and a range of general and specific supporters and inhibitors are identified (Table 21). Both individual and contextual factors serve to mediate the impact of L&D on engagement.

The study identified that staff can have a range of 'loci' for engagement, and presents a conceptual model for individual loci of engagement in NHS Lothian (Figure 6). The work group or team emerged as a particular locus for engagement, commitment and learning (Table 22). Work and organizational context was found to have an important impact upon engagement, and a conceptual model of the different contexts which impact on individual engagement is presented (Figure 7).

The study argues that insights into the complexity of engagement can be gained from understanding EE from the perspectives of staff. It argues for a focus on the interests of staff as individuals as well as on the priorities of the organization. Engagement, if we assume that it does exist as a separate construct to motivation or commitment, or a combination of these and other constructs, is not something that can be simply switched on by management interventions. It is individual, contextual, and multifaceted. Organizations can do some things to provide opportunities for engagement to occur, rather than seek to control individual engagement of employees.

Reflecting on the research

An interpretive research approach which seeks to generate insights through dialogue has stimulated and enabled deep critique of the topic of study. Chenail (1995) in discussing presentation of qualitative data suggests that the data should be 'the star' in the report. 'By that I mean, the main focus in qualitative research is the data itself, in all its richness, breadth, and depth' (no page no.) I hope that my account has been true to participants' words. But essentially research is a process of interpretation. Some of what respondents have said may be experienced as one-sided; for example, there were criticisms of management practices in the organization. Management has not been provided with an opportunity to respond, as that is not the purpose of this research, although I will present a report to the organization summarizing the research. This will focus on organization-relevant findings including staff perceptions of the drivers and barriers to EE; the contribution of L&D to EE

and factors which support and inhibit this contribution; and potential implications for the organization of the findings on locus of engagement, the role of the team in EE, and the impact of context on EE. The HR management of NHS Lothian approached the research in a spirit of open inquiry, by allowing me to do the research and recommending the topic of the research. It is not my intention to be ‘critical’ of the organization or its management, in a negative sense, rather than ‘critical’ in an inquiring sense. Alternative ‘frames’ can help people in organizations to think beyond the presenting problems (Bolman and Deal, 2008). I hope I have presented a fair representation, which demonstrates strengths and weaknesses.

Time has moved on - many things may have changed over the period of this study. I am aware for example that following on from the report highlighting concerns over the management culture at NHS Lothian that there have been a number of initiatives, not least over 150 meetings and workshops held with 3000 staff (... Evening News 25 July 2013). My research can only represent fully the moment in time that the fieldwork was conducted. Some of the themes that I discuss may be current today as they were when I ran the focus groups, whilst others may have changed.

Following the process of abductive, inductive and deductive reasoning as illustrated in the Thesis Conceptual Framework (Figure 3), this research can be considered as a work in progress. Gummeson’s (2000) hermeneutical spiral (Figure 2) illustrates how new understandings lead to new pre-understandings, in a continuous cycle, which suggests that ‘conclusions’ are only a partial reflection on a journey of inquiry and understanding. Since writing the literature review there has of course been more recent work about EE and health sector, or I have uncovered work that I did not find at the time, e.g. Maben’s (2008) case study of EE and retention in the nursing workforce of an inner-London acute trust. The subject continues, but this particular piece of work must conclude at this time.

Future research.

Shuck and Wollard (2010) urge HRD to become more involved in the area of EE, arguing that:

There is a short window of opportunity for the HRD field to take a leading role in fostering EE and to do so, the concept needs to be clearly defined and structured in a way that helps practitioners,

scholars, and researchers solve problems and offer solutions through a common language and understanding. (Shuck and Wollard, 2010 pp. 91–92)

This research suggests a number of areas for future research into the topic. The proposals on the significance of locus of engagement, teams as a specific locus of engagement, and the impact of context on engagement suggest areas for further research. The findings from the case study suggest further research focussing on staff perceptions of EE would be relevant. The research overall throws out a challenge for further research on EE to be critical in the utilization and adoption of the construct of EE. From a L&D perspective there is scope to continue to interpret the L&D contribution to establish the implications in terms of L&D interventions. There is significant evidence that L&D/HRD interventions contribute to EE as part of a package of measures. However, there is less evidence on specific L&D interventions and their contribution to EE. There is scope at different levels to explore HRD's contribution to engagement through working with teams, and an HRD perspective on the roles of 'engaging managers' has implications for research into the training of managers. There is also scope for cross-cultural studies, which has not really been touched on in this thesis. EE is presented as a universalist conception, and there is little examination of culture.

Limitations of the research.

I have tried to be clear on the limitations of case study research. I have tried to follow guidelines for quality in research in general and qualitative research in particular. There are things I could have done differently, decisions taken along the way that influenced the outcomes. I did not manage to include doctors in my study, which could have provided a more rounded amount of data. I would have liked to have followed up the focus groups with some more in-depth interviews with participants, and it would also be interesting to do follow-up focus groups. One of the limitations and a source of regret is the length of time that it has taken to complete the analysis and writing, which was mainly due to pressures from other commitments. I hope that the findings still have some validity for the organization.

References

- Alimo-Metcalfe, B., Alban-Metcalfe, J., Bradley, M., Mariathasan, J. and Samele, C. (2008) The impact of engaging leadership on performance, attitudes to work and wellbeing at work: A longitudinal study, *Journal of Health Organization and Management*, 22(6): 586–598.
- Allen, N. J. and Meyer, J. P. (1990) The measurement and antecedents of affective, continuance and normative commitment to the organization, *Journal of Occupational Psychology*, 63(1): 1–18.
- Alvesson, M. and Willmott, H. (2012) *Making Sense of Management: a critical introduction*, London, Thousand Oaks and New Delhi: Sage Publications.
- Alvesson, M. and Deetz, S. (2000) *Doing Critical Management Research*, London: Thousand Oaks and New Delhi: Sage Publications.
- Alvesson, M. and Skoldberg, K. (2009), *Reflexive Methodology: New Vistas for Qualitative Research*, 2nd Edition, London: Thousand Oaks and New Delhi: Sage Publications.
- Alvesson, M., Bridgman, T. and Willmott, H. (2009) Introduction, in M. Alvesson, T. Bridgman and H. Willmott, *The Oxford Handbook of Critical Management Studies*, Oxford, Oxford University Press, pp 1-28.
- Anderson, V. (2004) *Research Methods in Human Resource Management*, 2nd edition, Wimbledon: CIPD publishing.
- Andrews, T. (2012) What is Social Constructionism? *The Grounded Theory Review*, 11(1) <http://groundedtheoryreview.com/2012/06/01/what-is-social-constructionism/> Accessed 29.08.2013.
- Ashman, I. (2007) An investigation of the British organizational commitment scale, *Management Research News*, 30(1): 5–24.
- Attridge, M. (2009) Measuring and managing employee work engagement: A review of the research and business literature, *Journal of Workplace Behavioural Health*, 24(4): 383–398.
- Bacon, N. and Hoque, K. NHS Scotland 2010 Staff Survey, Highlights report.
- Bakker, A. B., Albrecht, S. L., and Leiter, M. P. (2011a) Key questions regarding work engagement, *European Journal of Work and Organizational Psychology*, 20(1): 4–28.
- Bakker, A. B., Albrecht, S. L. and Leiter, M. P. (2011b) Work engagement: Further reflections on the state of play, *European Journal of Work and Organizational Psychology*, 20(1): 74–88.
- Bakker, A. B. and Demerouti, E. (2008) Towards a model of work engagement, *Career Development International*, 13(3): 2009–2223.
- Bakker, A. B., van Emmerik, H. and Euwema, M. C. (2006) Crossover of burnout and engagement in work teams, *Work and Occupations*, 33(4): 464–489.

Beattie, R. (2002) Ethnographic research in HRD, in J. McGoldrick, J. Stewart & S. Watson (Eds). *Understanding Human Resource Development: a research-based approach*, London and New York: Routledge, pp.315-338.

BBC News 11 May 2012 Report says bullying is 'common in parts of NHS Lothian.

BBC News 23 April 2013 Nurses 'warned off whistleblowing in a culture of fear'.

BBC News 21 April 2013 Nurses 'drowning in a sea of paperwork'.

Bishop, J. W., Scott, K. D. and Burroughs, S. M. (2000) Support, commitment and employee outcomes in a team environment, *Journal of Management*, 26(6): 1113–1132.

Boaden, R.B., Marchington, M., Hyde, P., Harris, C., Sparrow, P.R., Pass, S., Carrol, M. and Cortvriend, P.B. (2008) *Improving Health Through Human Resource Management: The process of engagement and alignment*, London: CIPD.

Bolman, L.G. and Deal, T.E. (2008) *Reframing Organizations*, 4th edition, San Francisco: Jossey-Bass.

Bowles, J. and Associates (2012) *Investigation into the Management Culture in NHS Lothian*, May 2012.

Brewster, C., Higgs, M., Holley, N. and McBain, R. (2007) *Employee Engagement*. Report from the HR Centre of Excellence Research and Members meeting, Henley.

Brignall, S and Modell, M. (2000) An institutional perspective on performance measurement and management in the 'new public sector', *Management Accounting Research* 11: 281-306.

Bryman, A. & Bell, E. (2003) *Business Research Methods*, Oxford & New York: Oxford University Press.

Burrell, G. (2001) Critical dialogues on organization, *Ephemera*, 1 (1): 11-29.

Burrell, G., & Morgan, G. (1979) *Sociological Paradigms and Organizational Analysis*, Heinemann.

Callahan, J. (2007) Gazing into the Crystal Ball: Critical HRD as a Future of Research in the Field. *Human Resource Development International* 10, No.1: 77-82.

Chalofsky, N. and Krishna, V. (2009) Meaningfulness, commitment, and engagement: The intersection of a deeper level of intrinsic motivation, *Advances in Developing Human Resources*, 11(2): 189–203.

Charmaz, K. (2003) Grounded Theory: Objectivist and Constructivist Methods, in N.K. Denzin & Y.S. Lincoln (Eds) *Strategies of Qualitative Enquiry* (2nd Edition) London Thousand Oaks and New Delhi: Sage Publications.

Chenail, R.J. (1995) Presenting Qualitative Data, *The Qualitative Report*, 2 (3)
<http://www.nova.edu/ssss/QR/QR2-3/presenting.html>

Chia, R. (2000) Discourse Analysis as Organizational Analysis, *Organization*, 7, (3): 513-518.

CIPD (2008) *Employee Engagement*. CIPD Factsheet. London: CIPD.

CIPD (2011) *Locus of Engagement: Understanding what Employees Connect with at Work*. Research Insight, London: CIPD.

4-Consulting (2007) In association with DTZ consulting, *Employee Engagement in the Public Sector: A Review of Literature*. Edinburgh: Scottish Executive Social Research.

Clayman, S.E. & Teas Gill, V. (2009) Conversation Analysis, in M. Hardy & A. Bryman (Eds) *The Handbook of Data Analysis*, London Thousand Oaks and New Delhi: Sage Publications.

Clegg, S., Kornberger, M. and Pitsis, T. (2011) *Managing and Organizations*, London Thousand Oaks and New Delhi: Sage Publications.

Cohen, L. & Manion, L. (1994) *Research Methods in Education* 4th Edition, London and New York: Routledge.

Cohen, L., Manion, L. and Morrison, K. (2003) *Research Methods in Education* 5th Edition. London: Routledge Falmer.

Collins, M. (1995) Critical Commentaries on the Role of the Adult Educator: from self-directed learning to postmodernist sensibilities, in M.R. Welton (Ed) *In Defense of the Lifeworld: critical perspectives on adult learning*, Albany: State University of New York Press.

Coopey, J. (1995) The Learning Organization, Power, Politics and Ideology Introduction, *Management Learning*, 26 (2): 193-213.

Currie, G. and Learmonth, M. (2010) Introduction: Making Public Services Management Critical, in G. Currie, J. Ford, N. Harding and M. Learmonth (Eds) *Making Public Services Management Critical*, Abingdon and New York: Routledge, pp1-10.

Dale, M. (1994) Learning Organizations, in C. Mabey & P. Iles, *Managing Learning*, London, Routledge.

Davies, H. T.O. & Nutley, S. M. (2000) Developing learning organizations in the new NHS, *British Medical Journal* 320 (7240): 998-1001.

Davies, H. T.O., Nutley, S. M., & Mannion, R. (2009) Organizational culture and quality of health care, *Quality in Health Care* 9(2): 111-119.

Denscombe, M. (1998) *The Good Research Guide: for Small-scale Social Research Projects*, Buckingham and Philadelphia: Open University Press.

Employee engagement, learning and development in an NHS organization

Denzin, K.N & Lincoln, Y.S. (2003) Introduction: the discipline and practice of qualitative research, in N.K. Denzin & Y.S. Lincoln (Eds) *Collecting and Interpreting Qualitative Materials* (2nd Edition) London Thousand Oaks and New Delhi: Sage Publications, pp 1-46.

Denzin, N.K. & Lincoln, Y.S. (2011) Introduction; the Disciplines and Practice of Qualitative Research, in N.K. Denzin & Y.S. Lincoln (Eds) *Strategies of Qualitative Enquiry* (4th Edition) London Thousand Oaks and New Delhi: Sage Publications, pp1-19.

Dewey, J (1938) *Logic: The Theory of Inquiry*. New York: Holt, Rinehart and Winston.

Dick, P. (2006) Discourse Analysis, in C. Cassell and G. Symon (Eds) *Essential Guide to Qualitative Methods in Organizational Research*, London, Thousand Oaks and New Delhi: Sage Publications, pp 203-214.

Dicke, C. (2007) Employee engagement: I want it, what is it? *Employee Engagement: What Do We Really Know? What Do We Need to Know to Take Action?* A collection of white papers, Paris: Centre for Advanced Human Resource Studies, pp 5–17.

DiMaggio, P.J. and Powell, W.W. (1983) The iron cage revisited: institutional isomorphism and collective rationality in organizational fields, *American Sociological review*, 4: 147-160.

Donaldson, L. (2003) Organization theory as positive science, in H. Tsoukas and C. Knudsen (Eds) *The Oxford Handbook of Organization Theory*, Oxford and New York: Oxford University Press pp.1-36.

Doolin, B. (2003) Narratives of change: discourse, technology and organization, *Organization*, 10(4): 751-770.

Du Gay, P. (2003) The tyranny of the Epochal: change, epochalism and organizational reform, *Organization*, 10(4): 663-684

Easterby-Smith, M., Thorpe, R. & Jackson, P. R. (2008) *Management Research*, 3rd edition, London Thousand Oaks and New Delhi: Sage Publications.

Edmonstone, J. (1990), What Price the Learning Organization in the Public Sector? in M. Pedler, J. Burgoyne, T. Boydell & G. Welshman (eds), *Self-Development in Organizations*, London: McGraw-Hill, pp. 252–79.

Eisenhardt, K. M & Graebner, M. E (2007) Theory Building from Cases: Opportunities and Challenges, *Academy of Management Journal*, 50 (1): 25-32.

Fairlie, P. (2011) Meaningful work, employee engagement and other key employee outcomes: Implications for human resource development, *Advances in Developing Human Resources*, 13(4): 508–525.

Ferrer, J. (2005) *Employee Engagement: Is it Organizational Commitment Renamed?* Working paper series, Victoria University School of Management.

Fleming, P. & Spicer, A. (2007) *Contesting the Corporation: Struggle, Power and Resistance in Organizations*, Cambridge: Cambridge University Press.

Flesher, J. (2009) The meaning of work: A perspective from practice, *Advances in Developing Human Resources*, 11 (2): 253–260.

Fontana A & Frey JH (2003) The Interview: from structured questions to negotiated text, in N.K. Denzin & Y.S. Lincoln (Eds) *Collecting and Interpreting Qualitative Materials* (2nd Edition) London Thousand Oaks and New Delhi: Sage Publications pp. 61-106.

Franzosi, R.P. (2009) Content Analysis, in M. Hardy & A. Bryman (Eds) *The Handbook of Data Analysis*, London Thousand Oaks and New Delhi: Sage Publications, pp 547-566.

Garavan, T. N. (2007) A strategic perspective on human resource development, *Advances in Developing Human Resources*, 9(1): 11–30.

Gatenby, M., Rees, C., Soane, E. and Truss, C. (2009) *Employee Engagement in Context*. London, London: CIPD Publishing.

Gibbs, G.R. (2011) Coding part 3: what coding can be about.
<http://www.youtube.com/watch?v=3oo8ZcBJIEY>, accessed 30 Jan 2013.

Grant, D and Hardy, C. (2003) Introduction: struggles with organizational discourse, *Organization Studies* 25 (1): 5-13.

Grant, D., Iedema, R. & Oswick, C. (2009) Discourse and critical management studies, in M. Alvesson, T. Bridgman & H. Willmott, *The Oxford Handbook of Critical Management Studies*, Oxford & New York: Oxford University Press, pp 213 – 232.

Guest, D. E. and Conway, N. (2002) Communicating the psychological contract: An employer perspective, *Human Resource Management Journal*, 12(2): 22–38.

Harrison, R. and Kessels, J. (2004) *Human Resource Development in a Knowledge Economy: an organizational view*, Basingstoke: Palgrave Macmillan.

Harter, J., Schmidt, F. L. and Hayes, T. L. (2002) Business-unit-level relationship between employee satisfaction, employee engagement, and business outcomes: A meta-analysis, *Journal of Applied Psychology*, 87(2): 268–279.

Hatch, M.J. and Yanow, D. (2003) Organization theory as interpretive science, in H. Tsoukas and C. Knudsen (Eds) *The Oxford Handbook of Organization Theory*, Oxford and New York: Oxford University Press pp.1-36

Heron, J. and Reason, P. (1997) A Participatory Inquiry Paradigm, *Qualitative Inquiry* 3 (3): 274-294.

Hertzberg, F. (1966) *Work and the nature of man*, New York: The Word Publishing Company.

Higgs, M. (2006) Building Employee Engagement, *Henley Manager Update*, 18 (2).

Holstein, J. A. & Gubrium, J. F. (2004) The active interview, in D. Silverman (Ed) *Qualitative Research: Theory, Method and Practice*, 2nd Edition, London Thousand Oaks and New Delhi: Sage Publications, pp 140-161.

Johnson, P. & Duberley, J. (2000), *Understanding Management Research*, London: Thousand Oaks and New Delhi: Sage Publications.

Kahn, W. A. (1990) Psychological conditions of personal engagement and disengagement at work, *Academy of Management Journal*, 33(4): 692–724.

Kenealy, G.J.J. (2012) Grounded theory: A theory building approach, in G. Symon and C. Cassell *Qualitative Organizational Research: core methods and current challenges*, London, Thousand Oaks, New Delhi and Singapore: Sage Publications Ltd, pp. 408-425

Kirkman, B. L. and Rosen, B. (1999) Beyond self-management: Antecedents and consequences of team empowerment, *Academy of Management Journal*, 42(1): 58–74.

Kontakos, A. M. (2007) ‘Seeing clearly’ employee engagement and line of sight, *Employee Engagement: What Do We Really Know? What Do We Need to Know to Take Action?* A collection of white papers, Paris: Centre for Advanced Human Resource Studies, pp. 72–83.

Koschmann, T. (2003). CSCL, argumentation, and Deweyian inquiry: Argumentation is learning. In J. Andriessen, M. J. Baker & D. D. Suthers (Eds.), *Arguing to learn: Confronting cognitions in computer-supported collaborative learning environments*, Dordrecht, The Netherlands, Kluwer Academic Publishers pp. 261–269.

Lankshear C (1997) *Changing Literacies*, Buckingham and Philadelphia: Open University Press.

Latham, G. P. (2007) *Work Motivation: History, Theory, Research and Practice*. London: Sage Publications.

Learmonth, M. (2003) Making health services management research critical: a review and suggestion. *Sociology of Health and Illness*, 25 (1): 93-119

Learmonth, M. and Harding, N. (2004) Introduction. In M. Learmonth and N. Harding (Eds) *Unmasking Health Management – a critical text*, Nova Science Publishers, pp vii-x.

Lee, M. (2002) Defining the research question: in seizing the moment as the research question emerges, in J. McGoldrick, J. Stewart & S. Watson (Eds). *Understanding Human Resource Development: a research-based approach*, London and New York: Routledge, pp.18-40.

Lee, R.M & Fielding, N. (2009) Tools for qualitative data analysis, in M. Hardy & A. Bryman (Eds) *The Handbook of Data Analysis*, London: Sage Publications, pp. 529-546.

Liamputtong, P. (2009) Qualitative data analysis: conceptual and practical considerations, *Health Promotion Journal of Australia*, 20 (2): 133-9.

Lincoln, Y.S. & Guba, E.G. (1985) *Naturalistic inquiry*, London, Thousand Oaks and New Delhi: Sage Publications.

Lincoln, Y.S., Lynham, S.A. and Guba, E.G. (2011) Paradigmatic controversies, contradictions, and emerging confluences, revisited, in N.K. Denzin and Y.S. Lincoln (Eds)

The Sage Handbook of Qualitative Research, London Thousand Oaks and New Delhi: Sage Publications, pp. 97-128.

Lofland, J., Snow, D., Anderson, L., and Lofland, L. H. (2006) *Analyzing Social Settings: A guide to qualitative observation and analysis*, 4th Edition, Belmont, C.A: Wadsworth Thompson.

Loughlin, M. (2004) Orwellian Quality: The Bosses' Revolution, in M. Learmonth and N. Harding (Eds) *Unmasking Health Management – a critical text*, Nova Science Publishers, pp. 25-40.

Maben, J. (2008) *Employee Engagement and Retention in the nursing workforce: a case study of an inner-London acute trust*, National Nursing Research Unit, Kings College, London.

Macey, W. H. and Schneider, B. (2008) The meaning of employee engagement, *Industrial and Organizational Psychology*, 1(1): 3–30.

McBain, R. (2007) The practice of engagement, *Strategic HR Review*, 6(6): 16–19.

McCabe, T. J. and Garavan, T. N. (2008) A study of the drivers of commitment amongst nurses: The salience of training, development and career issues, *Journal of European Industrial Training*, 32(7): 528–568.

McCracken, M. and Wallace, M. (2000) Towards a re-definition of strategic HRD, *Journal of European Industrial Training*, 24(5): 281.

MacLeod, D. (2010) David MacLeod on employee engagement, *Management Today* 23 March, accessed 2 March 2012 <http://www.managementtoday.co.uk/news/992265/mt-special-david-macleod-employee-engagement/>

MacLeod, D. and Clarke, N. (2009) *Engaging for Success: A Report to Government*. London: Department for Business, Innovation and Skills.

McGuire, D. (2011) Assessing the effectiveness of training solutions, in D. McGuire and K. Molbjerg Jorgensen *Human Resource Development theory and practice*, London, Thousand Oaks and New Delhi: Sage publications pp.12-24

Mason, J. (2002) *Qualitative researching*, London: Sage.

Mathieu, J., Maynard, M. T., Rapp, T. and Gilson, L. (2008) Team effectiveness 1997–2007: A review of recent advancements and a glimpse into the future, *Journal of Management*, 34(3): 410–476.

Maylor, H. and Blackmon, K. (2005) *Researching Business and Management*, Basingstoke: Palgrave Macmillan.

Meyer, J. P., Becker, T. E. and Vandenberghe, C. (2004) Employee commitment and motivation: A conceptual analysis and integrative model, *Journal of Applied Psychology*, 89(6): 991–1007.

Miller J & Glassner B (2004) The “inside” and the “outside”, finding realities in interviews. In D. Silverman (Ed) *Qualitative Research: theory, method and practice, 2nd Edition*, London, Thousand Oaks and New Delhi: Sage Publications, pp. 125-139.

Molbjerg Jorgensen, K. (2011) Organizational learning and HRD, in D. McGuire and K. Molbjerg Jorgensen *Human Resource Development theory and practice*, London, Thousand Oaks and New Delhi: Sage publications pp.97-115

Murphy C., Cross, C. & McGuire, D. (2006) The motivation of nurses to participate in continuing professional education in Ireland, *Journal of European Industrial Training*, 30(5): 365-384.

Parker, S. K. and Griffin, M. A (2011) Understanding active psychological states: Embedding engagement in a wider nomological net and closer attention to performance, *European Journal of Work and Organizational Psychology*, 20(1): 60–67.

Pettigrew, A. M. (2012) Commentary: the Conduct of Qualitative Research in Organizational Settings, *Corporate Governance: An International Review*, 21(2): 123-126.

Pidgeon, N. & Henwood, K. (2009) Grounded Theory, in M. Hardy & A. Bryman (Eds) *The Handbook of Data Analysis*, London, Thousand Oaks and New Delhi: Sage Publications, pp.625-648.

Potter, J. (2009) Discourse Analysis, in M. Hardy & A. Bryman (Eds) *The Handbook of Data Analysis*, London, Thousand Oaks and New Delhi: Sage Publications, pp. 607-624.

Rapley, T. (2011) Some Pragmatics of Data Analysis, in D. Silverman (Ed) *Qualitative Research* 3rd edition, London, Thousand Oaks and New Delhi: Sage publications, pp. 273-290

Rigg, C., J. Stewart, and K. Trehan (2007) Introduction; a critical take on a critical turn in HRD. In *Critical Human Resource Development: Beyond Orthodoxy*. Eds. C. Rigg, J. Stewart, and K. Trehan, 1-16, Harlow, Essex: FT Prentice Hall.

Reed, M. (2000) The limits of discourse analysis in organizational analysis, *Organization*, 7(3): 524-530.

Remenyi, D., Williams, B., Money, A., & Swartz, E. (1998) *Doing Research in business and management, an introduction to process and method*, London, Thousand Oaks and New Delhi: Sage Publications.

Robertson, I. T. and Cooper, C. L. (2010) Full engagement: The integration of employee engagement and psychological well-being, *Leadership and Organization Development Journal*, 31(4): 324–336.

Robinson, D. (2003) *Defining and Creating Employee Commitment: A Review of Current Research*. HR Network Paper MP21, Institute for Employment Studies.

Robinson, D., Hooker, H. and Hayday, S. (2007) *Engagement: The Continuing Story*. IES Report 447, Institute for Employment Studies.

Robinson, S., Perryman, D. and Hayday, S. (2004) *The Drivers of Employee Engagement*. IES Report 408, Institute for Employment Studies.

Rocco, T.S. (2003) Shaping the Future: Writing up the method on qualitative studies, *Human Resource Development Quarterly*, 14 (3): 343-349.

Rorty, R. (1994), 'Method, Social Science, and Social Hope', in S. Seidman (ed.), *The Postmodern Turn: New Perspectives on Social Theory*, Cambridge: Cambridge University Press, pp. 46-64.

Ryan, W.G. & Bernard, H.R. (2003) Techniques to Identify Themes, *Field Methods*, 15 (1):85-109.

Saks, A. M. A. (2006) Antecedents and consequences of employee engagement, *Journal of Managerial Psychology*, 21(7): 600-619.

Sambrook, S. (2001) HRD as an Emergent and Negotiated Evolution: an ethnographic case study in the British National Health Service, *Human Resource Development Quarterly*, 12 (2):169-193.

Sambrook S. (2006) Management development in the NHS: nurses and managers, discourses and identities, *Journal of European Industrial Training*, 30 (1): 48-64.

Schaufeli, W. and Bakker, A. (2003) UWES Utrecht Work Engagement Scale, *Preliminary Manual* (version 1), accessed 16 April 2012
http://www.beanmanaged.eu/pdf/articles/arnoldbakker/article_arnold_bakker_87.pdf

Seijts, G. H. and Crim, D. (2006) What engages employees the most or, the Ten C's of employee engagement, *Ivey Business Journal Online*, March/April: 1-5.

Sheaff, R. & Pilgrim, D. (2006) Can learning organizations survive in the newer NHS? *Implementation Science*, 1(27): 1-11

Shuck, B. (2011) Four emerging perspectives of employee engagement: An integrative literature review, *Human Resource Development Review*, 10(1): 1-25.

Shuck, B., and A.M. Herd (2012) Employee Engagement and Leadership: exploring the convergence of two frameworks and implications for leadership development in HRD. *Human Resource Development Review* 11, No.2: 156-181.

Shuck, B., and T.G. Reio Jr. (2011) The Employee Engagement landscape and HRD: how do we link theory and scholarship to current practice. *Advances in Developing Human Resources* 13, No. 4: 419-428.

Shuck, M.B., T.S. Rocco, and C.A. Albornoz (2010) Exploring Employee Engagement from the employee perspective: implications for HRD. *Journal of European Industrial Training* 35, No. 4: 300-325.

Shuck. B. and Wollard, K. (2010) Employee engagement and HRD: A seminal review of the foundations, *Human Resource Development Review*, 9(1): 89-110.

Silverman, D. (2005) *Doing Qualitative Research*, London, Thousand Oaks and New Delhi: Sage Publications.

Silverman, D. (2011) *Interpreting Qualitative Research, 4th edition* London, Thousand Oaks and New Delhi: Sage Publications.

Singh, V. & Dixon, J. Ethnographic approaches to the study of organizations (2002) in D. Partington (Ed) *Essential skills for management research*, London, Thousand Oaks and New Delhi, Sage Publications, pp. 117-135.

Sinkovics, R.R. and Alfoldi, E.A. (2010) Facilitating the Interaction Between Theory and Data in Qualitative Research Using CAQDAS, in G. Symon and C. Cassell *Qualitative Organizational Research: core methods and current challenges*, London, Thousand Oaks, New Delhi and Singapore: Sage Publications, pp. 109-131.

Srivastava, A., Bartol, K. M., and Locke, E. (2006) Empowering leadership in management teams: Effects on knowledge sharing, efficacy, and performance, *Academy of Management Journal*, 49(6): 1239–1251.

Stake, R.E. (2003) *Case Studies*, in N.K. Denzin and Lincoln (Eds) *Strategies of Qualitative Enquiry*, London, Thousand Oaks and New Delhi: Sage Publications, pp.134-164

Stewart, J. (2005) The current state and status of HRD research, *The Learning Organization*, 12 (1): 90-95.

Storey, J., Wright, P.M., Ulrich, D. & Bhattacharya, M. (Eds) (2008) *The Routledge Companion to Strategic Human Resource Management*, London & New York: Routledge.

Storey, J. (1989) *New Perspectives on Human Resource Management*, International Thomson Business Press.

Thomas, G. (2013) *How To Do Your Research Project: A guide for students in education and applied social sciences*, 2nd Edition, London, Thousand Oaks and New Delhi: Sage Publications.

Thomas, P. (2003) The recontextualization of management: a discourse-based approach to analyzing the development of management thinking, *Journal of Management Studies* 40 (4): 775-800.

Thomas, R. and Davies, A. (2005) Theorizing the micro-politics of resistance: New Public Management and managerial identities in the UK public services, *Organization Studies*, 26(5) 683-706.

Towers Perrin (2008) *Closing the Engagement Gap: A Road Map for Driving Superior Business Performance*. www.towersperrin.com

Trewitt, L. & Glenn, S. (2011) *Views from the frontline: RCN Employment Survey 2011*, London: Royal College of Nursing.

Tsoukas, H. (2005) Afterword: why language matters in the analysis of organizational change, *Journal of Organizational Change Management*, 18 (1): 96-104.

Employee engagement, learning and development in an NHS organization

Tsoukas, H. and Knudsen, C. (2003) Introduction: the need for meta-theoretical reflection in organization theory, in H. Tsoukas and C. Knudsen (Eds) *The Oxford Handbook of Organization Theory*, Oxford and New York: Oxford University Press pp.1-36.

Valentin, C. (2006) Researching Human Resource Development: emergence of a critical approach to HRD enquiry, *International Journal of Training and Development*, 10 (1): 17-29.

Van de Ven, A.H. (2007) *Engaged Scholarship*, Oxford: Oxford University Press.

Van Maanen, J. (1988) *Tales of the Field: on writing ethnography*, Chicago and London: The University of Chicago Press.

Wallace, J. E. (1995) Organizational and professional commitment in professional and nonprofessional organizations, *Administrative Science Quarterly*, 40(2): 228–255.

Walton, J. (1999) *Strategic Human Resource Development*. Harlow, UK: Financial Times/Prentice Hall.

Waterman, R. H. Jnr, Waterman, J. A. & Collard, B.A. (1994) Towards a career-resilient workforce, *Harvard Business Review* July-August.

Welton, M. R. (1995) The critical turn in adult education theory, in M. R. Welton (1995) (Ed) *In defense of the lifeworld: critical perspectives on adult learning*, Albany: State University of New York Press.

Wilkinson, S. (2004) Focus Group Research, in D. Silverman (Ed) *Qualitative Research: Theory, Method and Practice, 2nd Edition*, London Thousand Oaks and New Delhi: Sage Publications, pp.177-199.

Willmott, H. (2003) Organization theory as critical science? Forms of analysis and ‘new organizational forms’ in H. Tsoukas and C. Knudsen (Eds) *The Oxford Handbook of Organization Theory*, Oxford and New York: Oxford University Press pp.1-36.

Yardley, L. (2000) Dilemmas in qualitative health research, *Psychology and Health*, 15 (2): 215-228.

Yin, R. (1994) *Case Study Research: Design and methods*, London, Thousand Oaks and New Delhi: Sage Publications.

Zigarmi, D., Nimon, K. I. M., Houson, D., Witt, D. and Diehl, J. (2009) Beyond engagement: Toward a framework and operational definition for employee work passion, *Human Resource Development Review*, 8(3): 300–326.

Reports

About the Knowledge and Skills Framework. Pay modernisation, NHS Scotland
<http://www.paymodernisation.scot.nhs.uk/afc/ksf/about.htm> Accessed 16/03/2009

Employee engagement, learning and development in an NHS organization

A development programme for improving the patient experience. NHS Lothian Board Meeting paper 28 Sept 2005

How Agenda for Change works. NHS Employers.
<http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/Afc-AtAGlanceRP.aspx> accessed 20.02.2009

NHS Lothian Human Resources and Organizational Development Strategy, November 2008-October 2011.

NHS Lothian Board Meeting 27 May 2009. Director of Human Resources and Organizational Development. Analysis of Staff Survey Data.

NHS Lothian Board Meeting 25 November 2009. Director of Human Resources and Organizational Development. Staff Survey 2008: Update.

NHS Lothian 2009-2010 October 2009-October 2010 Workforce Report

NHS Lothian What is IIP? IIP questionnaire for NHS Lothian Facilities.

NHS Lothian Board Meeting 26 May 2010. Planning for the future: NHS Lothian's five year plan 2009-2014

NHS Lothian Board Meeting 23 November 2011 Papers.

NHS Lothian Board Meeting 23 March 2011 Papers.

NHS Lothian Board Meeting 24 April 2013 Papers.

NHS Lothian Workforce Plan April 2006

NHSScotland Workforce information Overall Staff and Turnover
<http://www.isdscotland.org/Health%2DTopics/Workforce/Overall%2DStaff%2Dand%2DTurnover/> Accessed 21/05/2010

NHS Scotland Staff Opinion Survey 2008: Highlight report for NHS Lothian.

NHS Scotland Staff Opinion Survey 2008: Highlight report for NHS Scotland.

NHS Scotland Staff Governance Standard for NHS Scotland employees (2007). Scottish Executive, May 2007. NHS Scotland Staff Governance Standard, for NHSScotland Employees, 3rd Edition.

http://www.nhslothian.scot.nhs.uk/OurOrganization/BoardCommittees/LothianNHSBoard/BoardMeetings/BoardPapers/BoardPapersPreMay2011/050928_4-1.pdf

<http://www.scotland.gov.uk/Topics/Justice/law/Drugs-Strategy/recovery/HEAT>

<http://www.nhslothian.scot.nhs.uk/OurOrganization/KeyDocuments/AnnualReviews/NHS%20Lothian%202012%20Self%20Assessment.pdf>

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<http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/Afc-AtAGlanceRP.aspx>

Appendices

APPENDIX 1 Focus group planning information

Learning, Development & Employee Engagement in NHS Lothian



Your opinion counts!

What supports your motivation and focus to do your best in your job? What gets in the way? How can learning and development support you to do your job? What does employee engagement mean to you? These are some of the questions we will be exploring in focus groups to explore learning, development and employee engagement in NHS Lothian. The views and opinions of staff are central to this study.

What is the Learning, Development and Employee Engagement research project?

The purpose of the study is to explore the link between employee engagement and learning and development within NHS Lothian. The study emerges out of the 2008 bi-annual staff survey. The aim of the study is to develop a more in-depth understanding of staff experience of the drivers and barriers of employee engagement, and to highlight implications for learning and development in the organization. The study is supported by xx, Director of Human Resources & xx, Associate Director (Workforce Development).

Who is conducting the project?

The research is being conducted by Claire Valentin, a member of academic staff in the School of Education, The University of Edinburgh. The findings will be reported to NHS Lothian, and will help to inform staff governance action planning.

What will be expected of me if I participate?

A focus group is a group discussion led by the researcher. The focus group will last up to one hour, and will be guided by Claire. There will be about 6-8 people, with a list of questions to discuss. They will take place at a range of different locations within NHS Lothian. Refreshments will be provided. Individual participants will remain anonymous, and the findings from the discussion will be used to inform the research project.

Focus groups dates and venues

Nurses and Allied Health Professionals

NRIE	26 July (Monday)	14.15 – 15.15	Post Graduate Education Centre - Calton Room
	17 August (Tuesday)	14.15 – 15.15	Post Graduate Education Centre - Calton Room
WGH	28 July (Wednesday)	14.15 – 15.15	Conference Room. 4 Anne Ferguson Bldg
St John's	20 August (Friday)	14.15 – 15.15	Ladywell Room, Education Centre
CHP	19 August (Thursday)	14.15 – 15.15	Leith Community Treatment Centre Room 2

Administrative and Support Services staff

NRIE	27 July (Tuesday)	14.15 – 15.15	Seminar Room 3, Chancellor's Building
WGH	18 August (Wednesday)	14.15 – 15.15	Conf. Rm. 4 Anne Ferguson Bldg
St John's	29 July (Thursday)	15.15 – 16.15	Dean's Room, Education Centre

What to do next. If you offer to participate, further details on the focus group will be provided. Please pass your name to Claire by email or phone. Please get in touch if you have any questions. **Contact details.** Claire Valentin

APPENDIX 2 Research Project Information Sheet: Focus Groups

Learning, Development and Employee Engagement in NHS Lothian

You are being invited to take part in this research project. This information sheet gives details of why the research is being done and what it will involve. Please return the completed consent form or bring it with you to the focus group.

What is the purpose of the Learning, Development and Employee Engagement research project? The purpose of the study is to explore the link between employee engagement and learning and development within NHS Lothian. The study emerges out of the 2008 bi-annual staff survey. The aim of the study is to develop a more in-depth understanding of staff experience of the drivers and barriers of employee engagement, and to highlight implications for learning and development in the organization. The study is supported by the Director of Human Resources.

The study will take place within NHS Lothian, and will focus on the experience of several groups of staff: Nursing and Midwifery, Allied Health Professionals, Administrative Services; Support Services; Medical (including GPs). The study will be located in several different sites and departments. Issues will be explored in a series of one-to-one interviews, and a series of focus groups (group interviews) with a selection of participants drawn from each staff group.

Who is conducting the project? The research is being conducted by Claire Valentin, a member of academic staff in the School of Education, The University of Edinburgh.

Benefits of the Study. It is hoped that the study will be of benefit to staff in NHS Lothian, and to the wider research community. The findings will be reported to NHS Lothian, and will help to inform staff governance action planning. Findings will be written up in a research thesis, and in a research report to be submitted to NHS Lothian. This report would be made available for all research participants if interested.

What will you be asked to do? You are asked to consent to the following activity: Take part in a focus group lasting approximately 60 minutes. This is a group discussion led by the researcher, around a number of pre-determined topics. The focus group will be digitally recorded with permission of the participants.

What will the researcher do with the information you provide? The results of this participation will be confidential. Data generated by the research will be kept in a safe and secure location in the University of Edinburgh. It will be used purely for the purposes of the research project (including dissemination of findings). Computer based research data will be password protected. A coding system will be used for discussion and interview recordings and transcripts to protect the anonymity of participants. An identification number will be given and the names of participants will be removed. A separate password protected file containing names and identification numbers will also be kept. No one other than the researcher, supervisor or examiners will have access to any of the data collected. The recording of discussions and interviews will be destroyed three years after the completion of the study's data collection, analysis, and write-up. All necessary steps will be taken to protect the privacy of participants— e.g. by the use of pseudonyms, for individual participants, in any written reports of the research and other forms of dissemination. Where it

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might be appropriate for individuals' views to be identified, their permission will be sought. Contact details of participants will be kept confidential.

Ethical considerations. The research must comply with ethical guidelines for research for the Research Ethics Committee of the College of Humanities and Social Sciences, The University of Edinburgh. The framework for the ethical conduct of research is guided by principles of dignity, respect and care for others, honesty, integrity, objectivity, accountability, openness, and leadership.

Further information. Should you require any further information you can contact Claire at the contact details below: Claire Valentin, The University of Edinburgh, Tel. Email:

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FOCUS GROUP CONSENT FORM

Research project - Learning, Development and Employee Engagement in NHS Lothian

I agree to participate in the following activities in connection with this research project:

Focus group	Yes	No
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NAME.....

JOB TITLE.....

WORK ADDRESS

.....

.....

.....

TELEPHONE

EMAIL

Data from your participation will be recorded, stored and used in accordance with the procedures outlined in the Research Project Information Sheet. Your participation is voluntary and you can withdraw from the project at any time.

Please return this form to [\(email\)](#) or bring it to the focus group.

APPENDIX 3. Second level Coding example – Focus groups

<p>Employee Engagement comments</p> <p>General comments on EE.</p> <p>Participants in both focus groups and interviews were asked to comment on the concept of EE</p>	<p>NAHP</p> <p>F. I think, like you say the extra mile before was if you were interested in, you know, if you wanted to get involved in a development, you know, you were really supportive and encouraged. Whereas now it's kind of expected that that's part of your job. It's, it's not something that you get the gratitude for and appreciation now. It's just expected that you do work, that you'll do that extra stuff.</p> <p>I Right.</p> <p>F You don't maybe get the same, I don't know, it's not that extra any more</p> <p>NAHP</p> <p>F That's on the way it survives but I think the extra mile is more than a mile now.</p> <p>F Yeah now and again [unclear words 0:29:18] yeah it is.</p> <p>F They are expecting so much, yeah it is, they are expecting so much more than that extra mile, you know, it's with the staffing cuts.</p> <p>NAHP</p> <p>F. What a fantastic workforce the NHS has that's willing to go the extra mile even though they wouldn't recommend it as a good place to work [laughs].</p> <p>F I know [laughs]. It's quite a contradiction.</p> <p>I Yeah, I wonder why that is then?</p> <p>F I just think people, I mean, people come in to stay in, em, this kind of work because they like it because they, they get something out of it. So, job satisfaction, it must be [laughs]. But that doesn't necessarily mean that, I think they just, you ask people about the board. And the board is some faceless thing.</p> <p>I Right.</p> <p>F Miles away. And okay you might know the names of a couple of people who are on it. And they might come and you might just tidy up the ward and try to look good for the day. But other than that [laughs] what do they mean to, so it might be about the way...the way that the question's worded. (NOTE –REFERS TO QUESTION IN STAFF SURVEY)</p> <p>I Could be yeah yes yes.</p> <p>NAHP</p> <p>F. Or is it because people are, if you look at it quite negatively and say, you know, people don't like their, only go the extra mile in their work because they know they have to, it's a regular thing, you know.</p> <p>F [unclear words 0:26:56].</p> <p>F Yeah they just, they do it anyway, they do it every day in their working environment anyway. They always, maybe. And they are working, understaffed.</p> <p>I Right.</p> <p>F Or staying on a little bit late because you are continuously working understaffed and that's what you are just getting used to and that's the norm, I dunno. They could say that negatively.</p> <p>I Yeah.</p> <p>F And of course the extra mile for one person might be someone else's norm.</p> <p>I Mhmm.</p> <p>F And vice versa.</p>
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	<p>I Mhmm.</p> <p>F Someone might be saying well they wouldn't go the extra mile but actually they do on a regular basis.</p> <p>I Yeah right.</p> <p>F They just see it as the norm.</p> <p>I See it as the norm, that's interesting yeah yeah.</p> <p>NAHP</p> <p>F And I, I also think there's something that maybe goes back to management and how the place is organised.</p> <p>I Hmmm.</p> <p>F That if you, if you regularly are going the extra mile...</p> <p>I Hmmm.</p> <p>F ...if when you need the organization to be flexible with you, they can be flexible with you...</p> <p>I Yeah.</p> <p>F ...then, you know, you are more likely to get that.</p> <p>I And do you think that happens then?</p> <p>F Well it does where I work.</p> <p>F Yeah you get thanks for it obviously if you go the extra mile.</p> <p>I Right you do?</p> <p>F Yeah.</p> <p>F They appreciate that and...</p> <p>I You feel yeah, so it's a sort of give and take.</p> <p>F Mhmm.</p> <p>NAHP</p> <p>F. I think sometimes in an area where you get a lot of specialities coming through your area of work you don't necessarily know how well you are doing with regard to patient outcome in each speciality. And so if you get a morass of patients coming through perhaps through (specialism) or perhaps from, eh, (another specialism)...</p> <p>I Hmmm.</p> <p>M ...although you are looking after the patient on that day and you are educating someone about the patient on that day, you don't necessarily get to hear about how many (x) transplants were done or how many (x operations) were repaired successfully. Where as, because it's a big unit, it's a big hospital. Sometimes I think the size of the hospital, the number of patients that go through it and the number of specialities involved means you don't necessarily get a very clear handle on the difference you are making.</p> <p>I Hmmm and do you think that affects then, might affect how you feel engaged with the work to some extent?</p> <p>M I think it does.</p> <p>NAPH.</p> <p>F. I think, like you say the extra mile before was if you were interested in, you know, if you wanted to get involved in a development, you know, you were really supported and encouraged. Whereas now it's kind of expected that that's part of your job. It's, it's not something that you get the gratitude for and appreciation now. It's just expected that you do work, that you'll do that extra stuff.</p> <p>NAHP.</p> <p>F. They always want that bit more from you.</p> <p>I Yeah?</p> <p>F You've never done enough.</p>
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	<p>NAHP</p> <p>F. And, em, you know that is interesting actually. I think that, em, there has been, for example, a presentation which has been cascaded, I think, to pretty much everyone from the chief executive down about, you know, objectives from an organizational view in the context, it's interesting that it's kind of focused actually, the financial situation in some ways. A lot of that, we actually, have probably all been required to get a particular presentation. And people will say that to you. So, but I think it's, um, often your concerns amongst us all that there is that bit about what more can you do.</p> <p>F Mhmm.</p> <p>F And we probably all feel that we're, well we're actually probably at our peak anyway [laughs].</p> <p>NAHP</p> <p>M. And I think from the staff's perspective staff, they put under pressure, feel that you are not able to provide the service that you should be providing. And I think staff, that we have the work in the NHS are, are very committed just, everybody's said. Em, I think they want to do a good job and I think they want to, eh, make sure that the patients are getting the best that they should be getting. Em, and I think that's really important for us to be able to, em, have the opportunity to, to take staff with us. Because if you don't take staff with you then they are the ones that provide the service. It's not the people that are sitting in the offices that are providing the service. It's actually the staff on the ground. So they've got to be very careful that the staff have got that support and that commitment. And they know that the management are behind them in what they are actually delivering on a day to day basis. Em, but it's, it's a, it's a very challenging time for people.</p> <p>NAHP</p> <p>F. That's expected of you though to go that extra bit. You know, it doesn't matter how, how much. You've got to get through it, you've got to get to the goal posts.</p> <p>F And you've just got to do it for the sake of the patients.</p> <p>F Yeah that's right, you cannae, you know, you cannae say 'right it's half four, time I was out of here, I'm away'. You just, and if it's half past six. And then it just becomes 'oh well you stayed till half six yesterday, why can you not stay today'.</p> <p>F Mhmm.</p> <p>F And you stay till seven o'clock the next day. What, you know, 'why can you not do that today'.</p> <p>F And then they can't pay you and you can't take your TOIL.</p> <p>F Oh and you can't get the time back because there's no staff.</p> <p>F And you can't get the time back.</p> <p>F Yeah yeah.</p> <p>F You know, so it's a vicious circle.</p> <p>Admin.</p> <p>I. Right. And I mean what about this, some of the other questions there. What about 48% would recommend NHS Lothian as a good place to work.</p> <p>F1 It doesn't sound very nice.</p> <p>F2 No I'd like to know why the other 52% didn't.</p> <p>I Yeah, this is the problem with a survey like this. You don't really find out why.</p> <p>F2 Yeah.</p> <p>I Yeah.</p> <p>Admin</p>
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	<p>F1. They are involved in their job, they are doing their work with the same person like maybe their line manager is the same. Now see I'm the executive assistant to one of the directors. So all my colleagues are basically in the same role. So they're all working with the same person for a long time. So everything is like, you know, running on the rail track as it should, like the red lights, green lights, everything. And they are just moving ahead. What, whether they are totally satisfied, whether they are ready to engage in other things...</p> <p>I Hmmm.</p> <p>F1 ...or sort of like diversify their job or make it more interesting. But enthusiasm is not there.</p> <p>I Really.</p> <p>F1 So that's a bit missing.</p> <p>Admin.</p> <p>F. Yeah I mean, I think from an individual perspective, um, I think most people generally want to feel motivated to do their job well. I think most people want to feel involved. I think they want to go home at the end of the day and actually feel that they've done a good day's work for a fair day's pay.</p> <p>I Hmmm.</p> <p>F Um, and I think most people generally do feel, you know, the vast majority of people do feel committed to the organization. However, in the short length of time that I've been here, um, I think that there are so many constraints around what you can do that do impact on the motivation probably is the biggest one. Not necessarily for me as an individual.</p> <p>I Hmmm.</p> <p>F But I know certainly my team, I know that it is really really difficult to keep their motivation levels up.</p> <p>I Right yes hmmm.</p> <p>F Because, you know, the cutbacks that we're having, staff are not being replaced. And they are being asked to do more and more with no sort of, there's nothing in the distance to say this is a temporary thing. Now, you know, it doesn't mean that they are feeling less involved with what they do. Because if anything they are actually having to do more and have a greater involvement.</p> <p>I Right.</p> <p>F But I don't really feel that from their side of things that they necessarily actually go home and feel they've done, they are satisfied with the days work because I think a lot of them that are genuinely committed people to doing a good job, feel that they are not being able to do a full good job.</p> <p>I Hmmm.</p> <p>F Because they are having to really just sort of rush through things. So they...</p> <p>I Yeah yeah.</p> <p>F ...you know, that's where I think sort of, you know, it's difficult because it is separate from the employee engagement. But there are so many other contributing factors that impact on that.</p> <p>Admin.</p> <p>I. Any views on those, those findings?</p> <p>F1 They seem to be very low, personally don't they.</p> <p>F2 Yeah...the first one, 'I'm treated with dignity and respect in this organization', I think that's quite low.</p> <p>F1 Very low.</p> <p>F2 I think the percentage is quite low. And so...</p> <p>I Why would you think that is then?</p> <p>F2 ...if I was getting that back, if it was a survey that had been done just</p>
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	<p>purely on...em, my division...</p> <p>I Hmmm.</p> <p>F2 that would worry me if I saw that.</p> <p>I Yeah hmmm. What, you don't know why people have put that then, do you have any views?</p> <p>F2 Yeah yeah.</p> <p>F1 To be much more, this, question of dignity and respect now, everybody is treated very well. Right from down from a domestic to the CEO.</p> <p>I So in your experience...</p> <p>F1 I'm interacting with people from all the levels. And no everybody is treated with dignity and respect. I don't, I haven't come across anything.</p> <p>F2 No neither have I.</p> <p>I It's interesting, so...</p> <p>F2 [unclear words 0:38:10].</p> <p>F1 With me with seven months and X with twenty one years.</p> <p>F2 I haven't.</p> <p>F1 This is like a, this figure is bizarre.</p> <p>Admin</p> <p>I That's interesting, hmmm. So, yeah, so I think you've sort of talked quite a bit about some of the pressures really about, I suppose what might, contribute to employee engagement. You talked quite a lot about the sort of, the difficulty of working in such a pressurised environment then perhaps. Do you think that the idea of employee engagement is a relevant concept in the health service?</p> <p>F Absolutely yeah.</p> <p>F Yeah.</p> <p>I Yeah.</p> <p>NAPH</p> <p>F It definitely should be. It's just how it's done. Cause if it's not done well then it will have the absolute opposite effect and it will disengage people.</p> <p>I Mhmm.</p> <p>F So there's no point in doing it if you can't do it well.</p> <p>Admin.</p> <p>F Um, and, you know, you are asking people for opinions. We are giving opinions. But why is nobody actually taking any notice of what's been given? So from the public side of things I haven't got a great deal of experiences to see how that sort of, how that sort of compares with the private sector and well certainly from an (<i>former employer</i>) perspective. Um, but I just potentially see there being more constraints because just the environment that it is and sort of all the cutback, cutback, cutbacks.</p> <p>NAHP</p> <p>F Yeah it does seem to be a real disconnect and this is the first year that I've had any sense of engagement being a two way thing. Now suddenly we are trying to get Investors in People status suddenly all these miraculous things we've never seen before appear, like strategic objectives. I mean I know what my general manager's objectives are. I didn't have any clue that he had them, there hasn't previously been a sense that it wasn't just about us and our responsibilities.</p> <p>I Yeah so that's interesting, quite a recent thing.</p> <p>F Fairly recent.</p> <p>F Yeah two months.</p> <p>NAPH</p>
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	<p>F I think there's quite a, not a substantial, em, group of people who have no interest in learning or being engaged as an employee.</p> <p>F Hmm.</p> <p>F And just eh, em, come in and potter about and go home. But the sort of vast majority of staff are committed and go the extra mile and I personally find it quite hard when people do relatively little. And it's getting, about getting these people engaged.</p> <p>F Mmhmm.</p> <p>F But then that would make the sort of workplace even work better as a team.</p> <p>I Hmm.</p> <p>F So I mean that's, that's an area that's important to look at to find out how, to get people to read their emails or...</p> <p>F That's right, some folk just don't want to be engaged, that's it.</p> <p>F [unclear words – all speak at once 0:44:19].</p> <p>F That always annoys me.</p> <p>NAHP</p> <p>F. You know, when there's no choice and you are not getting valued or rewarded or recognised. That would annoy me.</p> <p>I Yeah. Other people were nodding about that. That's, that's a similar sort of thing?</p> <p>F We're quite, I would say our department is quite good. I mean you are not actively encouraged to stay back but if you are say in case conference or you are stuck with a patient like, you know, family member and you're an extra sort of half an hour, an hour over. You know, they say 'oh make sure you take your time back' I would say they're quite good there [unclear words 0:41:09].</p> <p>I That's good yeah.</p> <p>F Hmm.</p> <p>F Whether we get further opportunities to sometimes take it back is, you know, not always the case. But then that's your choice. You, I would sometimes, you are meant to leave half an hour earlier but I get caught up doing something else and that's my choice like you were saying.</p> <p>NAHP</p> <p>F. Yeah, I'm happy to go the extra mile at work when required I would say is very true of the role I'm in at the moment. Em, but I know that when I go back to ward (...) then I won't be happy going the extra mile [laughs]. Regardless, patient care obviously but sort of outwith that then no because it's, you don't get it recognised and you are not, not even, I was going to say rewarded by getting to go on courses and stuff. Cause it shouldn't be that it's a reward. But certainly, em, it's, it's different and I wouldn't think, I mean your like fire fighting and kind of just going in and doing your job then you are not happy to go the extra mile I don't think.</p> <p>I Really yeah.</p> <p>F And like well you, as soon as half past eight comes I'm, my jacket on and ready to go home. Whereas my job I'm in just now I've often found myself forty five minutes, an hour after and I should be going home and I'm quite happy to stay on and do what I'm doing because I'm getting job satisfaction. And what, the efforts that I'm putting in are getting recognised and, em, getting positive feedback from people which is something that isn't, doesn't happen where I'm going back tae.</p> <p>NAHP</p> <p>F. But there's not much more to give, I think. You know, if you take out, if you give people extra responsibilities.</p> <p>I Yeah.</p>
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	<p>F You can't keep doing it.</p> <p>I Yeah no.</p> <p>F Like there are a finite number of hours and I'm a finite person.</p> <p>I Hmm.</p> <p>F You know, I just, you know, there's only so much people can do. And we get burnt out as well, emotionally from it. I mean I think it's, I just don't know if we could take on extra things. I don't know what it, you need a bit of, a bit of stability. And it's just this thought that we might be going into another season of big changes and...</p> <p>F It's another fifteen seasons of big changes.</p> <p>F That's right.</p> <p>F According to the canyon (NOTE – A METAPHOR FROM THE VIDEO OF CHIEF EXEC. SPEECH).</p> <p>F ...it's exhausting, you know. That's the, because the organization is so big. You have to relearn so many different facets of it and then keeping up to date with the best research for patient practice. Like there's only so much energy going round, learning energy.</p> <p>I Yeah.</p> <p>F You know, you get into your forties and, you know.</p> <p>F And I feel like if you'd asked me this sort of five years ago I would be thinking in terms of like my extra mile would be doing extra things for patients, you know. Fitting extra wee bits and pieces in because that's our kind of job or that was our kind of job. Now my extra mile would be, if I was doing any, would be related to paperwork or office based stuff.</p> <p>I Yeah.</p> <p>F You know, so I suppose from that point of view my job isn't as satisfying as it once was.</p> <p>NAHP</p> <p>F. I think I'm becoming less tolerant to the extra mile because of the, what we are having to do as daily bread and butter is extra isn't it [laughs].</p> <p>F [unclear words 0:23:55] isn't it.</p> <p>I Really?</p> <p>F And I think they are factoring in charity from us.</p> <p>I Hmm.</p> <p>F And while they are having a level of, of, em ruthlessness about, and they might have to be ruthless about the organization but I am thinking, you know, 'I'll do what I'm paid to do in the manner that you are asking me to do it'.</p> <p>I Hmm.</p> <p>F And that will need to be enough, you know. Whereas before it would be, you know, more, em, easily sort of thing. 'No no, I'll do that', you know. But now I say 'well am I paid to do that' if there's something, extra on call or blah blah blah, you know. Whereas before I might have, you know.</p> <p>I Hmm so some things maybe changed then or...</p> <p>F Well I think we're, we're asked to do a lot every day.</p> <p>I ...yeah right.</p> <p>F Every single day.</p> <p>I Yeah.</p> <p>F And the extra mile now is, it's, is really, you know, cause we have increasing demands. And you don't know what they are until you are in and doing them. And it's not that I'm cynical or hate my job but I do think they, em, they need to realise that these are tough days and what they are asking to do just in terms of bread and butter is tough already.</p> <p>I Right.</p> <p>F And the extra mile isn't there because we're all having to put more effort in anyway.</p>
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Employee engagement, learning and development in an NHS organization

	<p>I Mmhmm absolutely, yeah.</p> <p>NAHP</p> <p>M But now there's no slack in the system just more pressure.</p> <p>F Mmhmm.</p> <p>M So I think goodwill is being eroded slowly. I am surprised that 83% of people will still say I'm happy to go to the extra mile. I'm pleased it's 83% but I'm surprised it's so high now.</p>
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APPENDIX 4. Third level Coding evidence Sample – Key Points. Focus groups

Themes/ Codes Code Descriptor	Key points, Positive	Key points, neutral, descriptive, normative	Key points, negative; problems and difficulties
<p>Employee Engagement comments</p> <p>General comments on EE.</p> <p>Participants in both focus groups and interviews were asked to comment on the concept of EE.</p>	<p>I am happy to go the extra mile in my current role because it is rewarding. But when I go back to the ward I won't feel the same.</p> <p>Admin staff feel engaged with the patients as much as clinical staff.</p> <p>Some of the findings of the survey are worrying. They don't reflect my experience or observations. I do see people being treated with dignity and respect.</p> <p>There is a learning culture in NHS Lothian.</p> <p>The vast majority of people do feel committed to the organization.</p>	<p>EE is a relevant concept to health sector.</p> <p>People all have different attitudes about whether they will take work home.</p> <p>The extra mile for one person might be someone else's norm.</p> <p>Some people just don't want to be engaged.</p> <p>There's a substantial group of people who have no interest in learning or in being engaged.</p> <p>Individuals' experiences differ.</p> <p>I have worked in different jobs. My feeling of engagement has varied depending on which place I am working.</p> <p>Nursing is very fast paced and there is shift work. I think it is easier for physios as we work normal shifts.</p> <p>If I get job satisfaction that contributes to engagement. Being valued and rewarded is important.</p> <p>If you see how your work fits into the bigger picture that helps engagement.</p> <p>We are all working towards the same targets.</p>	<p>We are already working at our peak.</p> <p>More and more is expected of staff.</p> <p>There's not much more to give.</p> <p>My job isn't as satisfying as it once was.</p> <p>They are doing their jobs but the enthusiasm is not there</p> <p>We get burnt out emotionally.</p> <p>There's not much more to give.</p> <p>They get their pound of flesh every day.</p> <p>Too much is now expected of me and that impacts on my feeling of engagement.</p> <p>I start thinking about getting another job.</p> <p>They always want that bit more from you. You have never done enough.</p> <p>We don't mind being busy but currently too much is expected- we are working longer and longer hours and firefighting.</p> <p>The extra mile is more than a mile now.</p> <p>The extra mile is now expected. And you don't get gratitude for it.</p>

Themes/ Codes Code Descriptor	Key points, Positive	Key points, neutral, descriptive, normative	Key points, negative; problems and difficulties
<p>Employee Engagement comments</p> <p>General comments on EE.</p> <p>Participants in both focus groups and interviews were asked to comment on the concept of EE.</p>		<p>You need the organization to be flexible with you. Its give and take.</p> <p>PDPs is a great system for engaging people when it works, but it's not always applied.</p> <p>A supportive manager is important to engagement.</p> <p>There are loads of initiatives. But we need more bodies to free staff up so there is someone to cover and they can be taken out of the clinic and go and do a PDP.</p> <p>If EE is not done properly it will have the opposite effect. There's no point in doing it if you can't do it well.</p> <p>Engagement can be done in an autocratic way or democratically. It's a good thing if done democratically, otherwise it has the opposite effect.</p> <p>How you fill in a survey will depend on your mood on the day.</p>	<p>I am becoming less tolerant of the extra mile because what we are doing as daily bread and butter is extra.</p> <p>The extra mile is not there because we are having to put in more effort anyway.</p> <p>The extra mile is now just an expected part of the job.</p> <p>There are so many constraints that impact upon motivation.</p> <p>It's difficult to keep up the motivation levels of my team, with the cutbacks and being asked to do more.</p> <p>Cutbacks are affecting people's motivation.</p> <p>Job satisfaction is affected.</p> <p>People's good will is being eroded.</p> <p>If you can't return the favour to your staff for staying on late then goodwill is eroded.</p> <p>Staff cannot get back their TOIL.</p> <p>A general culture towards admin/support staff pervades the organization.</p> <p>Cutbacks are affecting people's motivation.</p> <p>I see more constraints in the public sector because of cutbacks.</p> <p>I am happy to go the extra mile in my current role because it is rewarding. But when I go back to the ward I won't feel the same.</p> <p>Patients are the ones who suffer when we have to stay late to complete paperwork.</p>

Themes/ Codes Code Descriptor	Key points, Positive	Key points, neutral, descriptive, normative	Key points, negative; problems and difficulties
<p>Barriers to EE Comments on what gets in the way of EE</p> <p>Understanding the barriers and drivers to EE were a goal of the research</p>		<p>You can't be forced to be engaged, this would have the opposite effect.</p> <p>Some people just want to do their job.</p> <p>The organization can't do anything to make them feel more committed.</p> <p>During times of org change people don't feel that the org is committed to them.</p> <p>People doing the same job have been banded differently under Agenda for Change.</p>	<p>Morale is affected by the current climate.</p> <p>We've been told we need to do more for less and to expect this to last for the next 15 years. That affects EE.</p> <p>The cracks are beginning to appear.</p> <p>I am firefighting and I get less job satisfaction.</p> <p>Staff are on the edge of what they can deliver.</p> <p>There's no slack in the system. We cannot give people extra time back.</p> <p>Goodwill is being slowly eroded.</p> <p>You get demotivated.</p> <p>We don't feel empowered due to lack of resources.</p> <p>If I was younger I would be looking for another job.</p> <p>There are a lot of frustrations. I feel angry about things but you can't act on it.</p> <p>It's gone downhill in the last 2 years.</p> <p>There's a feeling of insecurity.</p> <p>Job satisfaction has fallen due to all the changes.</p> <p>You don't know if you will have a job tomorrow.</p> <p>I'm struggling to feel motivated.</p> <p>You have to rush through things, its not satisfying.</p> <p>I am worried I will have to compromise my assessments of patients to meet targets.</p> <p>People are feeling more stressed.</p> <p>If you raise concerns they can just be dismissed.</p> <p>Don't put your head above the parapet.</p> <p>You can't do your best for the patients.</p>

Themes/ Codes Code Descriptor	Key points, Positive	Key points, neutral, descriptive, normative	Key points, negative; problems and difficulties
Drivers of Engagement Comments on things that facilitate EE Understanding the barriers and drivers to EE were a goal of the research.	I feel committed. You want to give a patient continuity of care. We've all got professional standards and commitment to our patients. We are professionals. The idea of the NHS is the driver for the extra mile. Most people want to feel motivated. To do a fair days work for a fair days pay. If you see the bigger picture. If your objectives are clear. If you enjoy your job. Commitment to colleagues. You motivate yourself. I hated my last job (outside NHS), that's why I love this job. I feel very positive. If management roll up their sleeves and get stuck in. Feedback on your job, your efforts being recognised. If the organization shows some commitment to you. If you show your staff you value them. It is about the local connection and how we're valued as workers by those around us.	Job satisfaction comes from patient care (Admin). It's a personal thing, the organization cannot make people feel committed. Communication, being clear about things, involving staff in helping, in decision making. I think it's all about communication. If you have flexibility in how you do your work, a supportive manager. If you have a good team. A Strength based style of management, being appreciated. Having a good rapport with your manager. You have commitment to the team and to the patients. A good skills mix in the team. If you are given development opportunities. Learning and development opportunities Opportunities for learning. Good quality training. Knowing that they are going to get supported to do training. My current project comes with an intense learning package. Opportunity to put what you have learned into practice	I would not recommend this as a good place to work. But I do go the extra mile. Its grim for a lot of staff